HOSPITALS

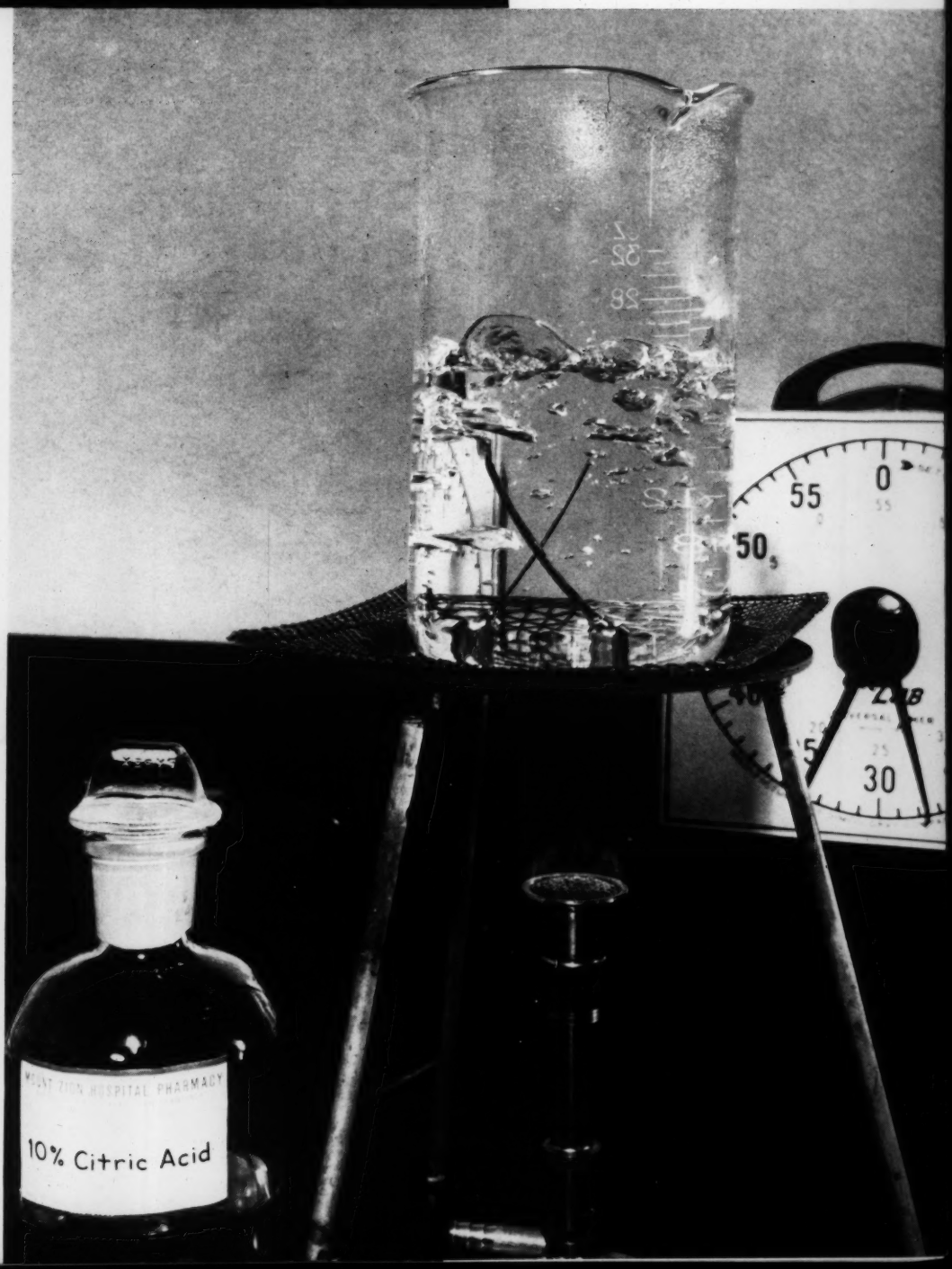
JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

JANUARY 16, 1957

Must the Mental Hospital Superintendent Be a Physician Psychiatrist?

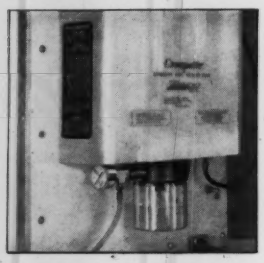
Insurance Coverages Needed During Construction

what to look for in purchasing hypodermic needles



4 new features

1. New CROUPETTE pressure gauge eliminates guesswork due to defective flowmeters. To produce optimal cool vapor, simply set flow to proper sector of gauge.



2. All operating instructions are located on the CROUPETTE itself; separate, legible panels at every point concerned. No more booklets to become dirty, dog-eared or lost.

3. New, stainless steel atomizing assembly is easier to clean, more durable, and should never need to be replaced. Adaptable to all earlier CROUPETTE models as well.

4. Wide-mouth, standard glass jar simplifies filling and cleaning, provides easier access to the new, stainless steel atomizer, and may be readily replaced if broken.

of the No.1 Croup Tent:

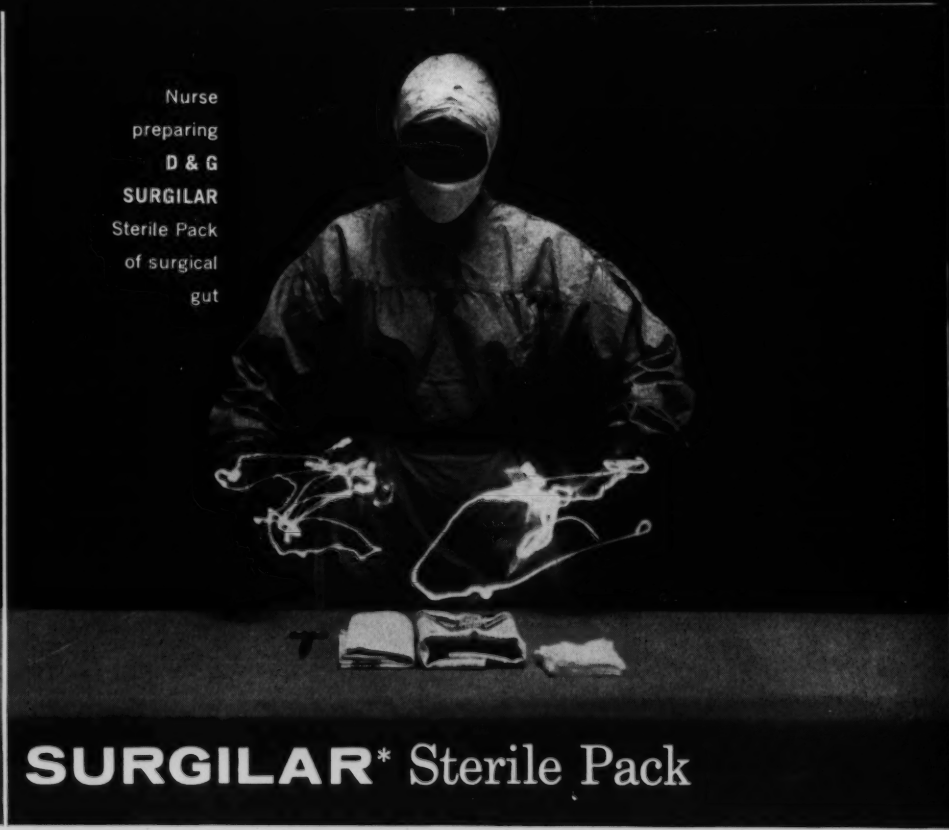
Visibility and accessibility are CROUPETTE features. This earlier model is as efficient as the day it was first used, more than seven years ago.

No wonder the CROUPETTE® *is standard equipment* in over 3,000 hospitals and 96 per cent of U. S. medical schools. First "cool-vapor" therapy tent, the CROUPETTE has no interior obstructions; no cumbersome, high-pressure connections. Ice chamber and controls are out of reach of patient, but easily accessible to the nurse. Fresh, moisture-saturated air is effectively cooled and oxygenated by exclusive CROUPETTE recirculation. Aerosol or oxygen therapy can be easily administered. Light, compact, portable, easy to set up or to store, and with no moving parts, the new, improved CROUPETTE is as simple as it is safe and efficient. Order now, with 30-day return privilege. Phone us collect: OSborne 5-5200 (Hatboro, Pa.)

The Croupette® portable, cool-vapor therapy tent

Designed, manufactured, sold and serviced by AIR-SHIELDS, INC. *Hatboro, Pa.*

Nurse preparing gut in glass tubes



Nurse preparing **D & G SURGILAR** Sterile Pack of surgical gut

Save suture handling with **D & G** **SURGILAR*** Sterile Pack

GET BROKEN GLASS OUT OF THE O. R.

Light-tracings in the time-and-motion pictures show a nurse's hands at work. Compare the simple motions she uses to prepare SURGILAR Sterile Pack of surgical gut with the many motions for tubed gut. She can handle SURGILAR ⅓ faster than tubes.

SURGILAR saves hospital nurse-power and money. It eliminates glass tubes, provides stronger, more flexible D & G surgical gut coiled in quickly opened, double, sterile transparent envelopes.

*Trademark

Hospital-tested SURGILAR helps to improve patient care. It keeps broken glass out of your O.R. No glass fragments to damage sutures, cut fingers, perforate gloves, or invade the operative field.

With SURGILAR, double envelopes are quickly cut, gut easily withdrawn, ready for use. No need to wash plastic envelopes after exposure, since they are protected by the outer envelopes. Jars store in ½ space required for tubed gut.

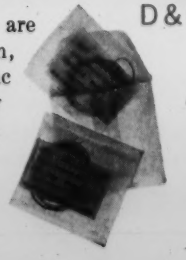


photo technic: *light-tracings of hands to which bulbs are attached.*

D & G **hospital-tested** packaging makes the difference

AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
DANBURY, CONNECTICUT

here . . . the peak season for respiratory infections, and for

V-CILLIN

(Penicillin V, Lilly)

The superior penicillin, more dependable than any other oral penicillin, and equal to parenteral penicillin in most infections.

now, a complete family of useful oral products:

Pulvules No. 20, 125 mg., bottles of 50
Pulvules No. 21, 250 mg., bottles of 24
Pediatric, 125 (M-125), bottles of 40 and 80 cc.
Pediatric, 250 (M-250), bottles of 60 cc.

and

'V-Cillin-Sulfa' (Penicillin V with Triple Sulfas, Lilly), Tablets No. 1801 and Pediatric (M-102)

733011

ELI LILLY AND COMPANY · INDIANAPOLIS 6, INDIANA, U. S. A.

hospitals | journal of the American Hospital Association

volume 31 *number 2* *january 16, 1957*

editor
Edwin L. Crosby, M.D.

executive editor
James E. Hague

managing editor
Aaron Cohodes

production manager
Newton J. Jacobson

contributing editor
Arnold A. Rivin

assistant editors
Barbara Elsholz
Eli Fritz
Rex N. Olsen
Charlotte M. Roller

advertising and business manager
Bremen I. Johnson

assistant business manager
Hal Levinson

advertising production manager
Martha E. Miller

circulation supervisor
Dorothy Heller

STAFF CONSULTANTS

LeRoy E. Bates, M.D.
Arthur H. Bernstein
Madison B. Brown, M.D.
Jack Dillman
Marian L. Fox, R.N.
Hilary G. Fry
Jose Gonzalez, M.D.
Sarah H. Hardwicke, M.D.
Richard L. Johnson
Ruth M. Kahn
John N. Hatfield II
Verne Kallejian
John T. Kelly
Edmond J. Lanigan
Marjorie M. Lawson
Catharine H. Loucks
Robert S. Marshall
James R. Neely
Maurice J. Norby
Joseph A. Oddis
David T. Riddell
E. John Rizos
William T. Robinson
Daniel S. Schechter
John E. Sullivan
Patricia Sussmann
Elton TeKolste
Alan E. Treloar
Gerald A. Weidemier
Kenneth Williamson
Clifford Wolfe
Helen Yast

articles

Must the Mental Hospital Superintendent Be a Physician Psychiatrist?
Yes — Addison M. Duval, M.D. — 34
No — Robert H. Klein and Paul E. Feldman, M.D. — 35
Insurance Coverages Needed During Construction — Sister Elise, S.C. — 39
Who Controls Your Hospital? — Gustav A. Killenberg — 41
An Analysis of a Fringe Benefit Program — George M. Harper Jr. — 44
Electronic System Aids Blue Cross Operation — Vernon Edwards and Bruce Taylor — 48
Air Conditioning the Hospital—Part 2 — Richard P. Gaulin — 50
Skin Bank Stores Postmortem Homografts — F. R. Bradley, M.D.; J. B. Brown, M.D.; M. P. Fryer, M.D.; and T. J. Zaydon, M.D. — 54
What to Look for in Purchasing Hypodermic Needles — Mark Berke — 60
We Cook with Microwaves — E. R. Park — 76

departments

Engineering and Maintenance — 68
Food Service and Dietetics — 76
Professional Practice — 54
Purchasing — 60

regular features

Accreditation Problems — Kenneth B. Babcock, M.D. — 24
Calendar of Association and Allied Meetings — 6
Digest of News — 17
Editorial Notes — 33
Equipment and Supply Review — 64
Introducing the Authors — 12
News — 87
Official Notes — 87
Opinions and Ideas — 28
Personal News — 75
Pro Re Nata — John H. Hayes — 103
Service from Headquarters — 20
The Literature — 86

cover

A telling test for the corrosion resistance of a hypodermic needle—boiling in citric acid for 30 minutes—can easily be carried out in the hospital. This and other tests for hypodermic needle quality are described in an article on page 60. Cover photograph by Mason Weymouth. (Other picture credits on page 106.)

Classified Advertising — 104
Index to Advertisers — 106

HOSPITALS is published the first and sixteenth of each month by the American Hospital Association, 18 E. Division St., Chicago 10, Ill. Entered as second class matter January 9, 1936, at the postoffice of Chicago, Ill., under the Act of March 3, 1879. SUBSCRIPTION RATES: $5 for 1 year; $9 for 2 years; $12 for 3 years. Single copies, 30 cents, except the two-part August 1, Guide issue, $2.50. (Foreign and Pan-American add $1 per year for postage.) CHANGE OF ADDRESS: Notice should include the old as well as new address including postal zone number. Four weeks' notice is required. The local postmaster should be notified. COPYRIGHT: January 16, 1957, by the American Hospital Association.

ADVERTISING REPRESENTATIVES

Chicago 10: *John S. Cassell, 18 E. Division St.—WHitehall 4-4350*
Chicago 10: *William W. Howe, 18 E. Division St.—WHitehall 4-4350*
Cleveland 15: *Eugene C. Leipman, 1220 Huron Rd.—SUperior 1-1373*
New York 22: *George B. Janco, 3 E. Fifty-fourth St.—PLaza 4-1090*
Pasadena 2: *Ren Averill, 234 E. Colorado St.—Ryan 1-9291*

Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with thromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had a good clinical result. One patient with lobar pneumonia had a good initial response but had delayed resolution after treatment

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. Abbott

filmtab®

Erythrocin®

(Erythromycin, Abbott)

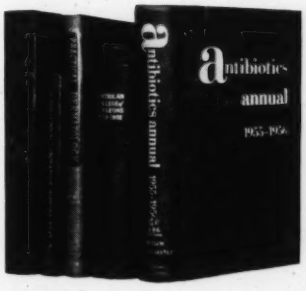
STEARATE

"No Serious Side Effects Occurred"

After a study of 171 patients treated with erythromycin, the investigator wrote: "No serious side effects occurred with prolonged therapy or with doses up to 8 Gm. per day in the severe infections."[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. In addition, you'll find allergic manifestations rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), in bottles of 25 and 100. Abbott

® Filmtab—Film-Sealed tablets, Abbott; pat. applied for.



1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48.
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

701051

hospital association meetings

AS SOON AS DETERMINED, NOTICE OF YOUR ANNUAL MEETING, AT WHICH OFFICERS ARE ELECTED, SHOULD BE MAILED TO DEPT. AH, 18 E. DIVISION, CHICAGO 10

NATIONAL HOSPITAL ASSOCIATIONS

American Hospital Association
Annual Convention—September 30-October 3; Atlantic City (Hotel Traymore)
Midyear Conference for Presidents and Secretaries of State Hospital Associations — February 4-5; Chicago (Palmer House)
American Protestant Hospital Association—February 27-March 1; Chicago (Palmer House)
Catholic Hospital Association—May 27-30; Cleveland (Hotel Statler)

REGIONAL MEETINGS

(THROUGH NOVEMBER 1957)

Association of Western Hospitals—May 6-9; Los Angeles (Statler Hotel)
Carolinas-Virginias Hospital Conference—April 11-12; Roanoke (Hotel Roanoke)
Maryland-District of Columbia-Delaware Hospital Association—November 18-20; Washington, D. C. (Shoreham Hotel)
Middle Atlantic Hospital Assembly—May 22-24; Atlantic City (Convention Hall)
Mid-West Hospital Association — April 24-26; Kansas City, Mo. (Hotel President)
New England Hospital Assembly—March 25-27; Boston (Statler Hotel)
Southeastern Hospital Conference—April 24-26; Atlanta (Atlanta Biltmore Hotel)
Tri-State Hospital Assembly—April 29-May 2; Chicago (Palmer House)
Upper Midwest Hospital Conference—May 22-24; Minneapolis (Hotel Leamington)

STATE AND PROVINCIAL MEETINGS

(THROUGH JUNE 1957)

Alabama Hospital Association—January 24-25; Montgomery (Whitley Hotel)
Arkansas Hospital Association—May 23-25; Little Rock (Marion Hotel)
Iowa Hospital Association—April 25-26; Des Moines (Hotel Savery)
Kentucky Hospital Association — March 26-28; Lexington (Hotel Phoenix)
Maine Hospital Association—June 11-12; Rockland (Samoset Hotel)
Massachusetts Hospital Association — May 9; Boston (Statler Hotel)
Michigan Hospital Association — June 21-22; Mackinac Island (Grand Hotel)
New Jersey Hospital Association—May 22-24; Atlantic City (Convention Hall)
New Mexico Hospital Association — March 11-13; Albuquerque (Hilton Hotel)
Hospital Association of New York State —May 22-24; Atlantic City (Hotel Claridge)
North Dakota Hospital Association — April 23-24; Grand Forks (Dacotah Hotel)
Ohio Hospital Association—March 31-April 4; Cleveland (Hotel Cleveland)
Hospital Association of Pennsylvania—May 22-24; Atlantic City (Convention Hall)
South Carolina Hospital Association — January 18; Columbia (Wade Hampton Hotel)
Tennessee Hospital Association—May 30-June 1; Gatlinburg (Hotel Mountain View)
Texas Hospital Association—May 14-16; Houston (Shamrock-Hilton Hotel)
Wisconsin Hospital Association—March 14; Milwaukee (Hotel Schroeder)

AHA INSTITUTES

(THROUGH JUNE 1957)

Hospital Dietary Department Institute—January 21-25; Minneapolis (Leamington Hotel)

(Continued on page 102)

This is how I felt Monday mornings before I discovered...

Now...we have Sterilwraps! Monday and everyday my work goes faster and smoother!

STERILWRAPS
FOR WRAPPING PACKS TO BE AUTOCLAVED

Safe, Re-usable, Economical Wrappers
The Nurse's Choice for Hospital Efficiency

STERILWRAPS are suitable for wrapping a wide range of soft goods and instruments, such as Lumbar Puncture Sets (above), Intravenous Sets, Drainage Sets, etc.

Convenient, easy-to-use, always available STERILWRAP Envelopes and Glove Cases insure maximum sterility retention.

Many small articles are conveniently packed in STERILWRAPS—towels, peritoneal pads, cotton, test tubes, throat swabs, culture tubes, syringes, etc.

Convenient: Always ready, even when the laundry and sewing room can't deliver. Take much less space.

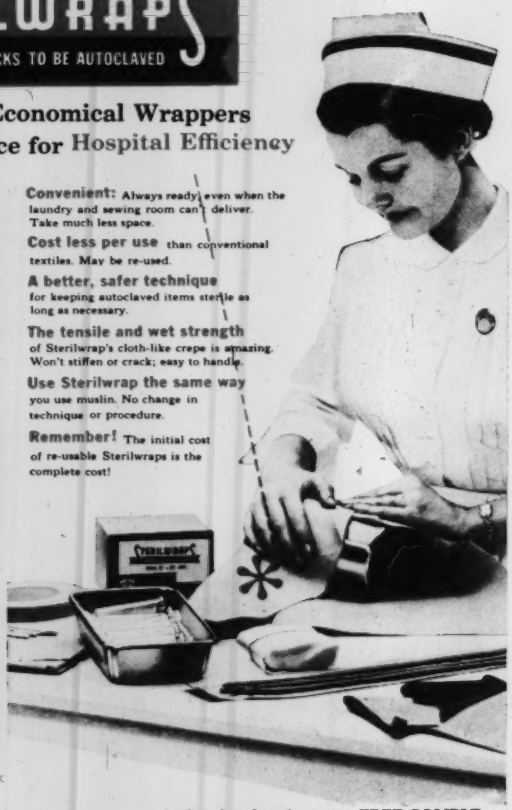
Cost less per use than conventional textiles. May be re-used.

A better, safer technique for keeping autoclaved items sterile as long as necessary.

The tensile and wet strength of Sterilwrap's cloth-like crepe is amazing. Won't stiffen or crack; easy to handle.

Use Sterilwrap the same way you use muslin. No change in technique or procedure.

Remember! The initial cost of re-usable Sterilwraps is the complete cost!



Test Sterilwraps yourself

Send today for your FREE SAMPLE TEST KIT, folder and price list. You owe it to yourself and your hospital to use the wrappers that save time, space, money and work.

MEINECKE & COMPANY INC.
Serving The Hospitals Of America For More Than Sixty Years

225 Varick St., New York 14 • 736 E. Washington Blvd., Los Angeles 21, Calif.
9012 Sovereign Row, Dallas 19, Texas • 701 College St., Columbia, S. C.

"I knew you'd be rushed—and I knew what you'd need!"

The pressure is on in X-ray. Never before have they handled so many patients – yet things are running smoothly. And there's not a hitch in sight.

Fact is, the radiologist never even had a chance to call for help. The administrator saw the rush coming – and beat him to the punch!

How? From his monthly reports the administrator was able to evaluate the coming situation – *before* it actually arrived. Figure facts on the utilization of special services by incidence of stay by kinds of patients alerted him to the changes taking place. And with this information at his command, he adjusted his budget *in time* to provide added help and facilities to meet the mounting demand on X-ray's services.

This is but one example of how proper figure facts can point up situations that demand administrative action. For further evidence, write to us today for your complimentary copy of "Better Patient Care Through Administrative Controls."*

**A paper delivered by John L. Mayer, Jr., at an A.A.H.A. conference, Orlando, Florida*

McBEE

Better patient care through administrative controls

The McBee Company, Athens, Ohio

Division of Royal McBee Corporation • *Offices in principal cities*

In Canada: The McBee Company, Ltd., 179 Bartley Drive, Toronto 16, Ontario

New from Bauer & Black

Now—An easy-to-handle

New Curity Adhesive is easy to unwind, easy to tear,

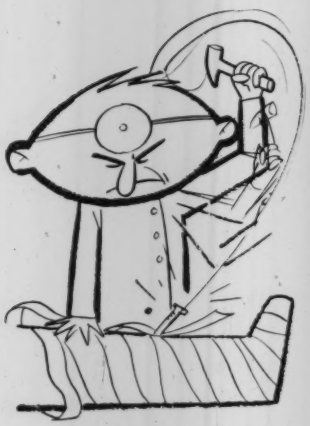
NOT THIS

NOW THIS

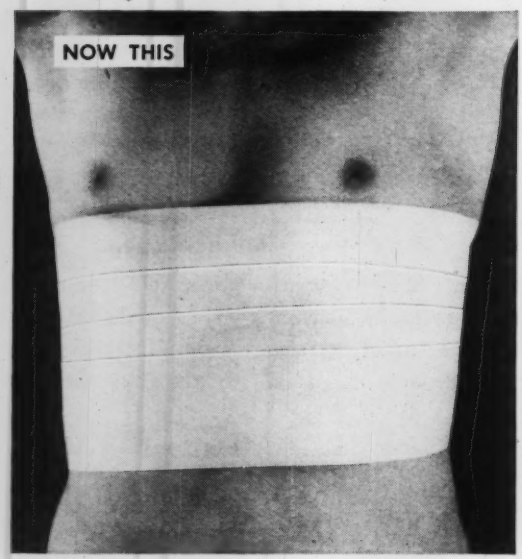
NOT THIS

New *Curity* Adhesive unwinds with the same gentle pull right to the very end of the roll. No more wasting the last couple of feet because you can't get it off the roll. And—*Curity* stays fresh.

NOT THIS



NOW THIS



NOT THIS

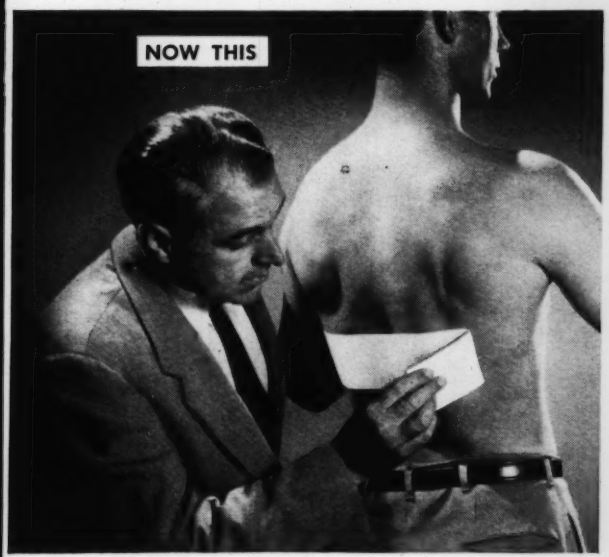
New *Curity* Adhesive sticks and *stays stuck*. Resists loosening by drainage, perspiration or even a shower bath.

Laboratories

adhesive that sticks

easy to apply—yet it *stays stuck* and it *stays fresh*

New *Curity* Adhesive is easy to apply. Won't wrinkle or tangle—because it has proper "body". It's up to 53% stronger than USP requirements—yet even the tiniest student nurse can tear it.



New *Curity* Adhesive is easy to remove—and it comes off *clean*. (No sticky mass left on skin.) And you can't put a less irritating adhesive on a patient.

Since the invention of adhesive tape, manufacturers have been faced with these sticky dilemmas:

If they made tape that would stay stuck, it was hard to pull off the roll and the patient. If they made tape with good tack (stickiness) it was too sticky to handle easily. If tape was flexible enough to conform to the body, it was too flimsy to handle. And if it was strong, it was hard to tear.

Now at last, after 4½ years of research, the Bauer & Black Laboratories have solved *all* these dilemmas. The result is New *Curity* Adhesive—the adhesive that combines ease of handling with high adhesive properties.

What's more, these balanced properties are built in to *stay:* a roll that's been in your drawer six months is just as fresh as one right from the factory.

Ask your Curity salesman for a "laboratory" demonstration right at your own desk.

You get these new adhesive qualities in every Curity adhesive product you buy.

NEW Curity® ADHESIVE

BAUER & BLACK

Division of The Kendall Company
309 West Jackson Blvd., Chicago, Ill.

"Our Otis Maintenance delivers needed to coordinate

"We're very much interested in uninterrupted elevator service," says GEORGE MASSENGILL, Chief Engineer. "It's one of the most important functions of a modern hospital. It coordinates all visitor and patient services.

"The new PROVIDENCE HOSPITAL was erected in 1952. We installed five OTIS Passenger Elevators and four OTIS Electric Dumbwaiters and put them under OTIS Maintenance.

"We believe that OTIS is best equipped to maintain its installations. It understands every detail of operation. It has special maintenance equipment. And it has an 'engineered program' for replacing parts in advance of their breakdown point with original OTIS parts. In fact OTIS does everything possible to avoid shutdowns which can have serious consequences in a hospital."

Otis

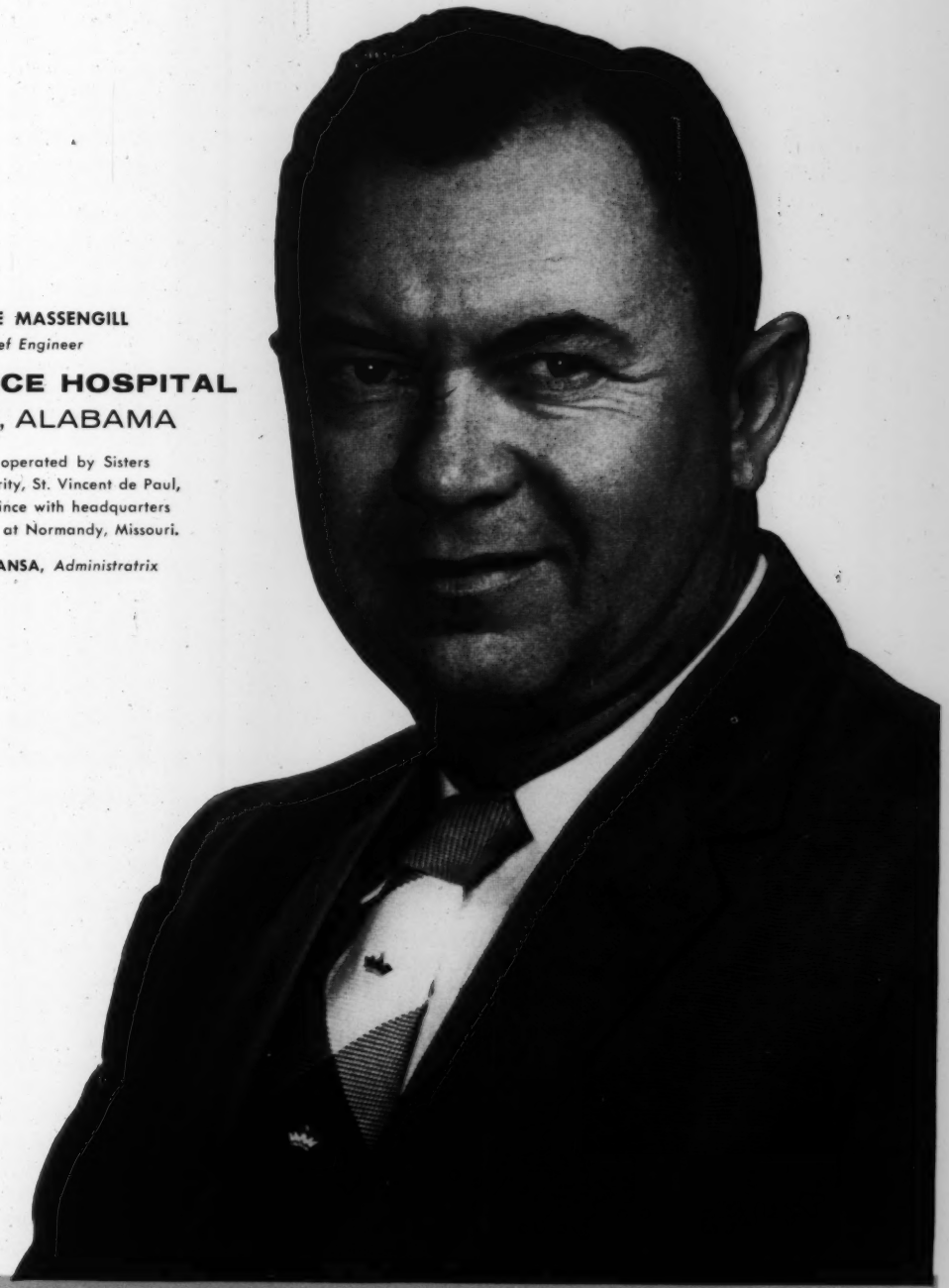
"WORLD'S WORD FOR ELEVATOR QUALITY"

elevators

that increase a building's prestige

OTIS ELEVATOR COMPANY • 260 ELEVENTH AVENUE • NEW YORK 1, N. Y.

the elevator performance
all visitor and patient services"



GEORGE MASSENGILL
Chief Engineer

PROVIDENCE HOSPITAL
MOBILE, ALABAMA

This hospital is operated by Sisters of Charity, St. Vincent de Paul, Western Province with headquarters at Normandy, Missouri.

SISTER ALPHANSA, *Administratrix*

Otis

"ENGINEERED SERVICE BY THE MAKER"

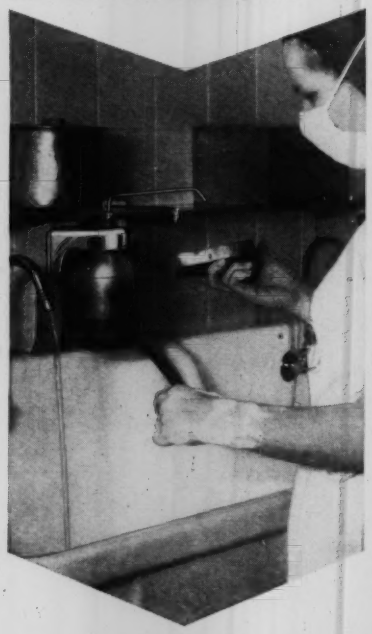
maintenance

that keeps elevators running like new

OFFICES IN 297 CITIES ACROSS THE UNITED STATES AND CANADA

Here's a way

TO KEEP HANDS SURGICALLY CLEAN AND BEAT THE BUDGET, TOO



USE Germa-Medica®

Liquid Soap with Hexachlorophene

Laboratory tests show that a simple 3-minute wash using Germa-Medica Liquid Surgical Soap with Hexachlorophene is an effective surgical scrub, yet it costs only 1/5¢ per washing! Why? Because this highly-concentrated bacteriostat may be diluted with up to four parts water and still reduce the bacteria count below safe levels and *keep it there.*

Germa-Medica is highly concentrated fine soap, combined with the bacteria-destroying Hexachlorophene and an emollient. Germa-Medica will not irritate the most tender hands . . . it contains soothing olive oil.

Write today for free samples of Germa-Medica with Hexachlorophene. Test for yourself the remarkable germicidal action of this practical, economical Liquid Surgical Soap. Huntington also has a complete line of Surgical Soap Dispensers.

HUNTINGTON

HUNTINGTON LABORATORIES

Huntington, Indiana

Philadelphia 35, Pa. • Toronto 2, Canada

introducing the authors

Must the mental hospital superintendent be a physician psychiatrist?

NO

by Robert H. Klein & Paul E. Feldman, M.D.

Robert H. Klein, active for many years in philanthropic work, is perhaps best known for his service in the field of mental health.

Mr. Klein is a member of the board of governors of the Menninger Foundation; consultant to the Mental Hospital Service and American Psychiatric Association; and a member of the advisory panel of the Joint Commission on Mental Illness and Health.

From 1949 to 1953, Mr. Klein was special deputy to the director of the Dept. of Public Welfare, state of Illinois. During this time, he made administrative audits of state institutions, and worked on numerous administrative projects.

DR. FELDMAN

He received his bachelor of philosophy degree from the University of Chicago School of Business Administration. A major in the U.S. Army, Mr. Klein served as medical administration officer with the 16th Evacuation Hospital during World War II.

Paul E. Feldman, M.D., is director of research and education, Topeka State Hospital, Kansas. Dr. Feldman took his bachelor of science degree at the University of Chicago, and his medical degree at the University of Illinois College of Medicine.

His psychiatric residence was served at the Institute for Juvenile Research, Chicago.

He was formerly assistant superintendent of Manteno State Hospital and Alton State Hospital, both in Illinois.

Dr. Feldman's memberships include: American Medical Association, American Psychiatric Association, and the Illinois, Kansas and Mid-Continent Psychiatric Societies.

YES

by Addison M. Duval, M.D.

Addison M. Duval, M.D., superintendent of St. Elizabeths Hospital, Washington, D.C., received his degree from the Medical College of Virginia in 1929. His internship and special training in psychiatry were taken at St. Elizabeths, and he has been there since beginning his professional career.

The U.S. Dept. of Health, Education, and Welfare gave him the superior service award for public service beyond the call of duty, and the award of the Medical Society of the District of Columbia for professional contributions to the health, welfare of the children of Washington, D.C.

DR. DUVAL

Dr. Duval is clinical professor of psychiatry, George Washington University Medical School; a diplomate of the American Board of Psychiatry and Neurology; and a certified mental hospital administrator.

What to look for in purchasing hypodermic needles

by Marke Berke

Marke Berke, administrator of Mount Zion Hospital, describes several tests for determining the quality of hypodermic needles. These tests were developed in conjunction with a representative of a manufacturer of such equipment.

Mr. Berke was formerly a member of the accounting staff of the Hospital for Joint Diseases, New York City. In 1945 he became controller at Mount Sinai Hospital in Cleveland. While there he became administrative assistant, then assistant director.

Prior to his present position at Mount Zion, San Francisco, Mr. Berke was administrator of Mount Sinai Hospital at Philadelphia.

Spend Less for Heating and Cooling— Provide Ideal Thermal Conditions with JOHNSON *INDIVIDUAL ROOM* CONTROL

Los Angeles Health & Receiving Hospital, Los Angeles, California. Lunden, Hayward & O'Connor, architects; Ralph E. Phillips, mechanical engineer; Western Air & Refrigeration, air conditioning contractor; all of Los Angeles.

The impressive new Health & Receiving Hospital in Los Angeles illustrates how any hospital can realize the *full* benefits of air conditioning and, in so doing, save money on the cost of heating and cooling.

The entire building is air conditioned, using eight modern double duct air conditioning systems to deliver hot and cold air to all points in the building. Mixing dampers, controlled by sensitive Johnson Room Thermostats, correctly proportion the supply of hot and cold air at the point of discharge into each space. Other Johnson controllers regulate the pressures within the ducts to insure uniform air distribution.

The exceptional flexibility of this control arrangement makes it a simple matter to satisfy each one of a wide variety of temperature requirements. High speed teamwork between Johnson Thermostats and the damper operators keeps the temperature in each space at the exact level desired. With Johnson *Individual Room* Control, heating and cooling output is continuously matched to actual needs, and the unnecessary expense of overheating and overcooling is effectively eliminated.

Further economy is achieved by varying the temperature of the hot air supply of each system in accordance with outdoor temperatures, thus minimizing heat output. The entire system functions without attention from the hospital's professional staff.

These and other modern features of Johnson Control can help any hospital provide ideal temperature conditions for every purpose while substantially reducing heating and cooling costs. Regardless of what type of heating, ventilating or air conditioning system your problem involves, a Johnson-engineered Control System is the best answer. An engineer from a nearby branch office will gladly give you his recommendations without obligation. Johnson Service Company, Milwaukee 1, Wisconsin. Direct Branch Offices in Principal Cities.

JOHNSON CONTROL

SINCE 1885

PLANNING • MANUFACTURING • INSTALLING

X-RAY INSTALLATION PLANNING

a General Electric service in step with your progress

Insuring x-ray department efficiency

PLANNING a new hospital? Enlarging or modernizing existing facilities? The logical starting point for any construction project involving x-ray facilities is to plan with your General Electric x-ray representative. Preliminary "shirt sleeve" sessions with administrator, architect, radiologist and others involved, first determine your specific needs. The planning can then be expertly handled by our Installation Planning Service.

With your requirements in mind, this full-time staff of specialists considers every possible operating advantage and convenience: How to arrange equipment and make space work more profitably . . . power, wiring and protective requirements . . . plumbing and other arrangements are carefully analyzed. The layout offered the architect is based on your receiving the ultimate in service from your x-ray equipment.

Hospital architects have relied on this General Electric service for years because this vast experience provides hundreds of practical application advantages. Ask your General Electric x-ray representative for complete details while you're still in the planning stage.

In the meantime, you'll want a copy of this fact-packed booklet

With x-ray diagnostic and therapy loads increasing, it will pay you to investigate the many new developments in the General Electric line. This 20-page guide to the completely modern x-ray department contains diagrams showing traffic flow through administrative, diagnostic and therapy areas as well as film processing and special departments. You'll also find informative suggestions on related facilities — even locations of windows. For your copy, see your General Electric x-ray representative. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wis., for Pub. L-17

Progress Is Our Most Important Product

GENERAL ELECTRIC

B. F. Goodrich develops surgeons' glove that proves highly effective in most cases of contact dermatitis

"Eudermic" special purpose glove solves problem for many surgeons allergic to ordinary rubber

FOR years, surgeons who were allergic to ordinary rubber gloves had constant trouble, sometimes had to stop operating.

Glove manufacturers tried to do something about it. Synthetic material was tried. It helped as far as the dermatitis was concerned. But it couldn't be as thin as rubber. It didn't have the sensitivity and comfort.

After experiments with many types and grades of rubber and different manufacturing techniques, B. F. Goodrich found the answer. They continued to make the gloves out of pure rubber latex, but developed a process that removes those irritating ingredients that cause contact dermatitis or further aggravate conditions resulting from other allergies.

The result is a special purpose glove that B. F. Goodrich calls "Eudermic". While immunity from dermatitis can't be guaranteed in every case, thousands of doctors are now using these gloves successfully.

Of great importance is the fact that not one of the fine features of B. F. Goodrich gloves was sacrificed in developing these gloves. The "Eudermic" glove is just as thin, just as strong, and just as comfortable as other B. F. Goodrich surgeons' gloves.

Because of their uniform strength, B. F. Goodrich surgeons' gloves—regular type as well as "Eudermic"—withstand frequent autoclavings and continue to give perfect service, operation after operation. They retain their elasticity and can be stored for months with no fear of deterioration. To save time in sorting, B. F. Goodrich stamps the size on surgeons' gloves in big, easy-to-see, colored numerals.

These modern gloves are products of B. F. Goodrich research. Choose from the complete line of B. F. Goodrich gloves carried by leading hospital and surgical supply houses:

"Miller" brand surgeons' gloves—Long wrists. Sizes 6 to 10. Three colors: hospital green, white, brown. Two finishes: smooth or cutinized.

"Miller" brand examination gloves—Short length cuff. Sizes 7 to 9. White only.

"Eudermic" special purpose gloves—Sizes 6½ to 9½. White only. Cost is only pennies more per pair.

Other B. F. Goodrich products for hospital service include a wide variety of precision-made catheters, rubber tubing, of all kinds, Koroseal translucent tubing, sheeting, ice caps, water bottles, throat and spinal packs, and bulb syringes. For more information, write *Sundries Sales, B. F. Goodrich Industrial Products Company, Akron 18, Ohio.*

B.F.Goodrich

Surgeons' Gloves

Institutions MAGAZINE

FIRST Award

FOR HIGHEST STANDARDS OF SANITATION AND FOR SUPERLATIVE ACHIEVEMENT IN STORING, HANDLING, PREPARING AND SERVING FOOD

ask "WHY ?" —and profit!

In Institution's 1956 Food Service Contest Winners,
HOBART MACHINES
OUTSCORED
ALL OTHER BRANDS
COMBINED

PRODUCT	NUMBER OF AWARD KITCHENS USING THIS TYPE MACHINE	PERCENTAGE OF HOBART INSTALLATIONS IN AWARD CLASS	AVERAGE NUMBER OF HOBART MACHINES PER INSTALLATION
Cutters, Food	36	67%	1.29
Dishwashers	45	62%	1.43
Glasswashers	32	72%	1.26
Mixers	41	95%	2.53
Peelers	38	61%	2.00
Saws, Meat	17	53%	1.00
Slicers	38	74%	1.39
Tenderizers, Meat	10	50%	1.20

45 Food Service establishments received awards

Trademark of Quality Hobart for over 55 years

Hobart machines

The World's Largest Manufacturer of Food, Kitchen and Dishwashing Machines

Ask why—in 8 machine categories—Hobart, with 50% or more of the totals, surpassed all other brands combined. Ask why kitchen managers, stewards and chefs—famous as careful, shrewd buyers—so prefer the Hobart quality and superior performance backed by the greatest name in the food, kitchen and dishwashing machine industry.

Ask yourself—your friends in the business—your own well-established local Hobart representation. Ask—get the answer—and profit. **The Hobart Manufacturing Co., Troy, Ohio.**

HEW 1957 PROGRAMS ANNOUNCED—In a series of special news releases during the first week of January, Department of Health, Education, and Welfare Secretary Marion B. Folsom detailed the areas in which his department would be seeking funds for its 1958 budget.

Secretary Folsom announced that he would ask Congress for more than $200 million for medical research for the National Institutes of Health. Last year Mr. Folsom requested more than $126 million for medical research. Other health areas and programs announced by Secretary Folsom as priority items for congressional action were:

1. More funds to help medical, dental, and public health schools build teaching and training facilities.
2. A new federal program to provide federal support for research into the basic causes of poverty and dependency.
3. A federal-state grant program to help relieve a shortage of professional workers trained to deal with dependency problems.
4. A new and more comprehensive program to demonstrate the ability of severely disabled persons to do useful work.
5. An expanded program of federal aid to improve Indian hospitals and extend public health services to the Indian population.
6. Increased funds to expand Food and Drug Administration activities. HEW will ask for an increase of $2 million to control standards over the output of new foods and new drugs.

McGUINNESS, RICHARDSON TAKE HEW POSTS—Dr. Aims C. McGuinness has been sworn in as special assistant for health and medical affairs to the secretary of the Department of Health, Education, and Welfare. He succeeds Dr. Lowell T. Coggeshall who recently resigned.

Elliot L. Richardson has been sworn in as HEW assistant secretary succeeding Roswell B. Perkins.

Both appointments are subject to Senate confirmation.

Dr. McGuinness, 51, has been a member of the faculty of the University of Pennsylvania School of Medicine since 1934, and assistant to the associate professor of pediatrics from 1946 to 1951. He served as dean at the university's Graduate School of Medicine from 1951 to 1954.

From 1948 to 1951, Dr. McGuinness was director of Children's Hospital, Philadelphia. During World War II he served as assistant administrator for the Army Epidemiological Board.

DR. McGUINNESS

MR. RICHARDSON

In 1954 he was clinical director of the Miners Memorial Hospital Association of the United Mine Workers Welfare and Retirement Fund. Dr. McGuinness has been in private practice in Philadelphia since leaving the association.

Mr. Richardson, 36, received his law degree from Harvard Law School in 1947. He has served as law clerk to Judge Learned Hand and Judge Felix Frankfurter and has been in private law practice.

Mr. Richardson will assist in the development and coordination of the department's programs, especially in activities related to legislation, HEW stated.

TOLEDO HOSPITALS, UNION COME TO AGREEMENT—Hospitals and unions in Toledo, Ohio, have agreed to allow a six-man Community Board of Appeals to act as final arbiter in settling problems involving working conditions there.

The agreement was reached after an unauthorized 7-week strike by 10 maintenance men who were trying to gain union recognition at Mercy Hospital.

Toledo hospitals signed a statement containing these points:

- "All hospitals recognize that, while their primary duty is to the patients, they also have basic obligations to their employees and to the public.
- "The hospitals recognize the right of any employee of his or her own free choice to join a union or any other organization for his or her benefit or advancement without being subject to discrimination because of such membership.
- "The hospitals will provide for their employees appropriate and adequate grievance procedures regarding working conditions and wage adjustments, with employee representatives elected by the employees from their own ranks and with a right of review by a committee from the respective board of trustees or advisors of each hospital."

The Community Board of Appeals is to be composed of two members designated by the hospitals jointly, two designated by the Toledo AFL-CIO, and two "public members" named by the other four.

An official union statement, issued at the same time as the hospitals' statement, read in part:

". . . As a citizen, the unionist knows that the collective bargaining of the commercial enterprise cannot be transplanted to the hospital . . .

"Slowdowns and work stoppages in a hospital can become matters of life and death. No responsible unionist can, therefore, talk of strikes or slowdowns in relation to hospitals . . .

"With the growth of unions in the community and the benefits of dignity and security which unionism bestow upon the union mem-

Worth Quoting

". . . The health of the people is really the foundation upon which all their happiness and all their powers as a state depend . . ."—Lord Beaconsfield (Disraeli) *in a speech July 4, 1877.*

ber, the hospital employee naturally seeks the same status and in the same manner. On the other hand, the hospital is not comparable to the shop, the factory, the warehouse, the retail store.

"Union leadership in Toledo feels that reasonable men acting as citizens first and managers and unionists second can resolve this problem. It is further hoped that this may be a Toledo contribution to the national problem of unionization of hospitals."

Unions do not have official recognition by the hospitals as bargaining agents for employees.

Employees may elect members of a committee to present their problems, grievances, or suggestions to the hospital administration or to the board of appeals.

It was stated that the employees' committee "is not a consulting committee and definitely it neither renders decisions nor concurs in them."

MINE WORKERS-HOSPITAL DISPUTE BEING DISCUSSED—Officials of Citizens General Hospital, New Kensington, Pa., and the United Mine Workers Welfare and Retirement Fund were scheduled to meet Jan. 7 to discuss a hospital staffing dispute that began three years ago.

The hospital's medical staff has refused to extend staff privileges to doctors affiliated with the UMW-sponsored Russellton Clinic.

The union group has refused to pay members' hospital bills incurred at Citizens General, except in emergency cases.

BABIES ESCAPE HARLEM HOSPITAL FIRE—Ninety-eight children, 31 of them premature babies, were removed without incident from Harlem Hospital, New York City, when a smoothly-operating evacuation plan was put into effect during a fire there Jan. 5.

Approximately 140 nurses and student nurses and 100 other staff members assisted in the evacuation. For several years the hospital has had a standby emergency plan ready to put into operation, Dr. Bernard B. Nadell, medical superintendent, said. The plan was put into effect as soon as the emergency condition arose.

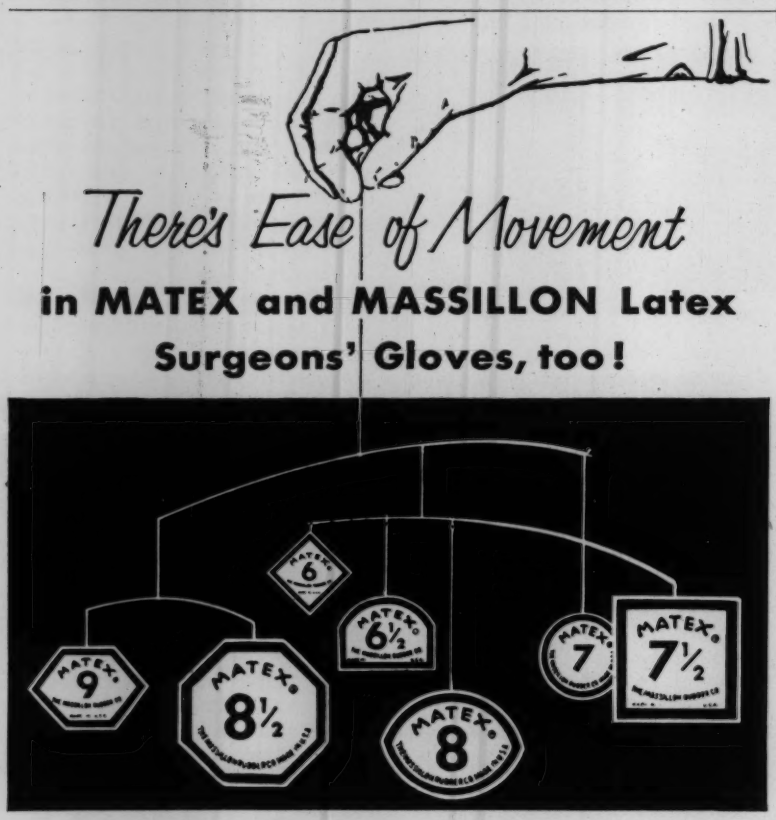
The fire was discovered at 4:30 a.m. in a new nine-story annex being constructed next to the five-story pediatrics building. Patients are housed only in the upper two stories of the children's unit. Sixty-one children were transferred to neighboring hospitals and six others were discharged.

FIRE FORCES 39 PATIENTS FROM HOSPITAL—Thirty-nine patients were evacuated from 85-bed Charity Hospital, Savannah, Ga., after a fire was discovered at the hospital on Jan. 2 at approximately 4 a.m.

Nurses and other staff members put the hospital's emergency plan into effect immediately; the evacuation was accomplished without panic or injury.

Twenty-six evacuees were admitted to the Memorial Hospital of Chatham County, which reported no difficulty in handling the sudden influx of patients. The remaining patients were discharged.

Operating rooms, supply rooms, laboratories, and assembly rooms on the top floor of the 25-year-old, 3-story Charity Hospital were gutted.



One reason why surgeons prefer MATEX and MASSILLON Latex gloves is the ease of movement resulting from the MATEX comfort-curing process. This more expensive method of curing in live steam is still used exclusively on both these gloves.

Coupled with the advantages of permanent and indestructible Kwiksort size markings that speed sorting and pairing, and their long life, it's understandable why hospitals prefer MATEX and MASSILLON Latex Surgeons' Gloves.

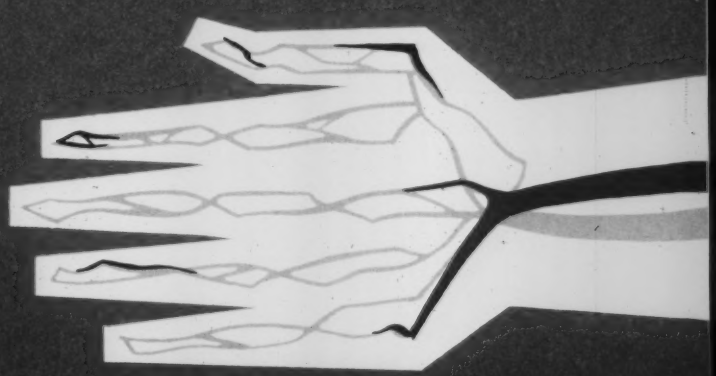
MATEX Kwiksort MASSILLON LATEX

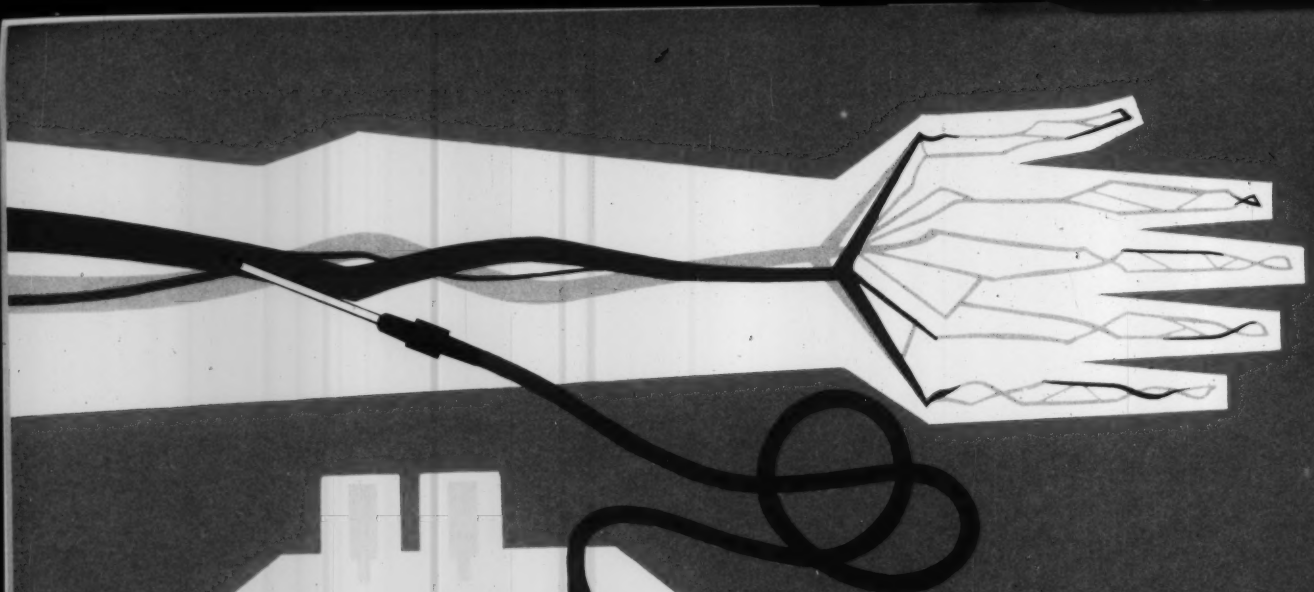
The MASSILLON RUBBER COMPANY
Massillon, Ohio

Better Blood...from Donor to Patient

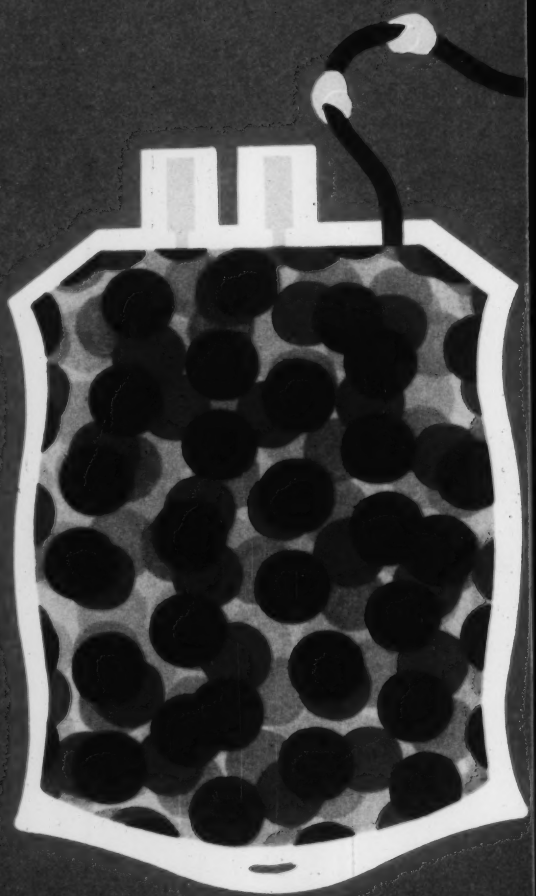
FENWAL® Plastic Blood Handling System

ETHICON®





THE ONLY CLO
Collection, Pro



Collection of Blood... safe, sterile, simple

Plastic Blood-Pack® with integral donor tube and phlebotomy needle—all in one unit.

Sterile, pyrogen-free, closed system minimizes danger of bacterial contamination and reduces patient reactions.

Special Laminar Flow Phlebotomy Needle and hemorepellent surfaces minimize platelet aggregation and destruction, reducing clotting.

Improves platelet yield — delivers more viable red blood cells.

Rapid infusion without danger of air embolism— no stoppage or slowdown

Filter before drip-chamber eliminates fibrin web and ensures discrete drip.

Superior filter chamber prevents stoppage or slowdown.

Squeezing of Blood-Pack® provides rapid infusion when needed without danger of air embolism.

ED SYSTEM for ssing, Infusion

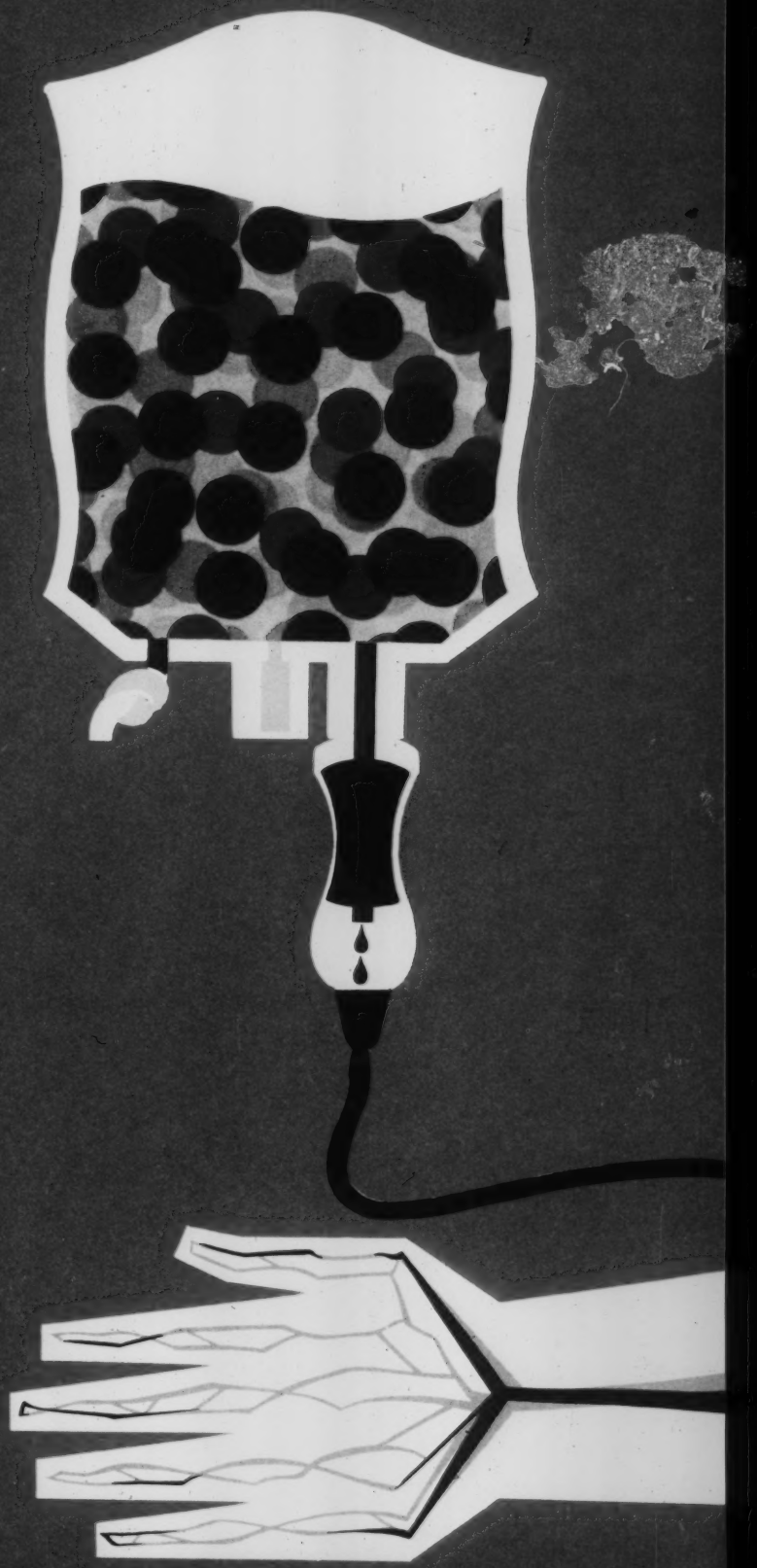
Processing and Storage without red cell deterioration or contamination

Numbered donor tube provides for identifiable segmented aliquots . . . blood samples available for typing, cross matching and sterility tests without contamination of blood in plastic Blood-Pack®.

Blood easily and economically separated into pediatric doses.

Blood components—separated red cells, plasma, platelets—available for specific therapeutic use.

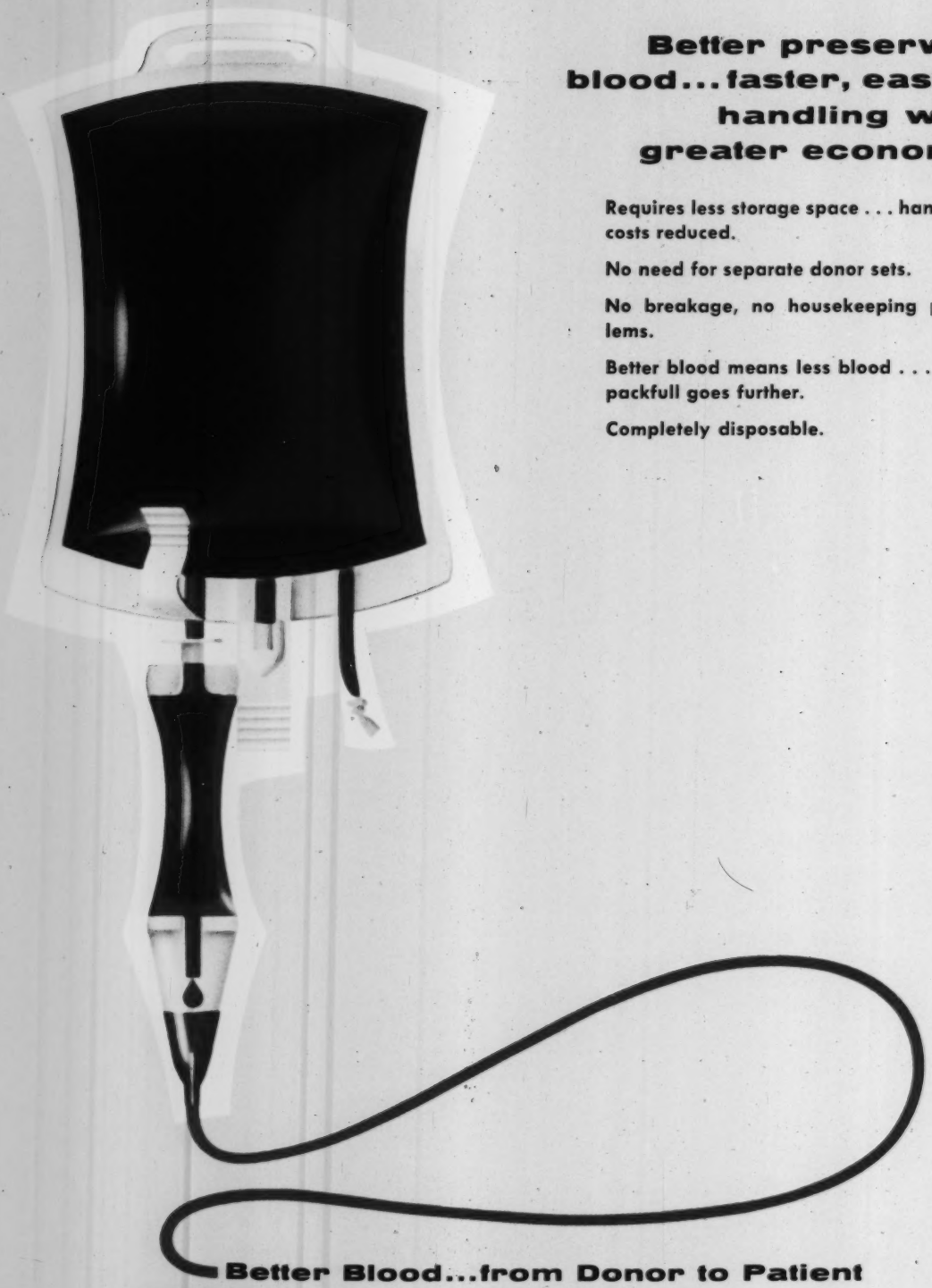
More viable red cells for infusion.



FENWAL®

ETHICON®

*Blood-Pack is the registered Trade Mark of Fenwal Laboratories, Inc.



Better preserved blood... faster, easier handling with greater economy

Requires less storage space . . . handling costs reduced.

No need for separate donor sets.

No breakage, no housekeeping problems.

Better blood means less blood . . . each packfull goes further.

Completely disposable.

Better Blood...from Donor to Patient

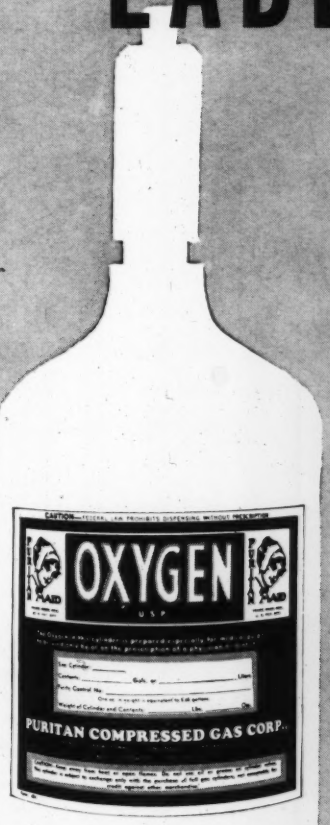
FENWAL® Plastic Blood Handling System

DISTRIBUTED EXCLUSIVELY BY

ETHICON®

SOMERVILLE • NEW JERSEY

YOU WON'T FIND IT ON THE LABEL



The Puritan label does not say "Since 1913." Neither does it say anything about those years since 1913 which are the key to the Puritan tradition of purity and service.

In 1913, Puritan began producing medical gases. At the same time, Puritan pledged that every product would be backed by integrity, service and dependability. Today, that pledge is still unbroken . . . still the nucleus of the Puritan tradition.

Puritan

COMPRESSED GAS CORPORATION
SINCE 1913

KANSAS CITY, MO.

PRODUCERS OF MEDICAL GASES
AND GAS THERAPY EQUIPMENT

Local auxiliary support

What can our auxiliary do to secure greater support and participation from the local community?

In general, we find that this particular problem can be solved by telling the community more about the auxiliary, what it does and what it can do to serve the hospital and, therefore, the community. It can also encourage greater community participation by developing specific auxiliary projects which interests the community and by building auxiliary meetings around the particular needs of the community.

Type V institutional membership in the American Hospital Association provides continuing help to hospital auxiliaries in solving this particular problem as well as many other problems. One of the principle aids this membership provides to hospital auxiliaries is the *Hospital Auxiliary Newsletter*, the official monthly publication which keeps member auxiliaries up-to-date on what similar organizations are doing.—PATRICIA SUSSMANN

Tuberculosis care

Is it safe, from a standpoint of infection, to build a tuberculosis hospital and home for the aged in close proximity?

Where modern medical practices are in effect in modern institutions, there is no reason not to build a tuberculosis hospital and a home for the aged in close proximity.

As a matter of fact, if a general hospital is equipped to take care of a patient with pneumonia it can also, by providing well known and easily established precautions, care for tuberculosis patients in the same building without additional risk of infecting employees or non-tuberculosis patients.

I would suggest that you write to: Tuberculosis Program, Division of Special Health Service, Department of Health, Education, and Welfare, Public Health Service, Washington 25, D. C., requesting a copy of the publication *Guide for a Tuberculosis Control Program for General Hospitals.*

—LEROY E. BATES, M.D.

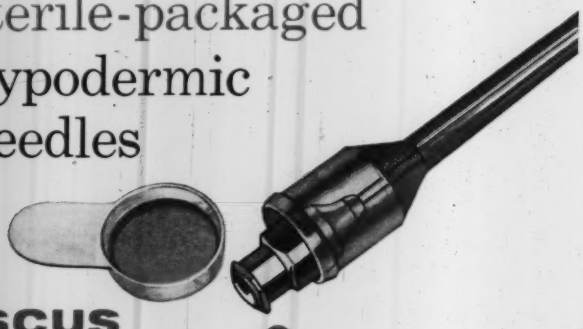
Surgical privileges

We have a problem determining just what surgical privileges each staff member is eligible to be entitled to and would appreciate any information that could help us.

There is no uniform or standard set of requirements for granting

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

now
sterile-packaged
hypodermic
needles



DAMASCUS
needles in
NEEDLETAINERS

Sterile to start with . . . simple to use. Damascus Needles in Needletainers mark a revolutionary advance in needle packaging. Now . . . Standard American Luer needles come to you *pre-sterilized* in an individual reusable nylon case that protects the points. No more autoclaving and cleaning of new needles. Needletainers keep Damascus Needles *sterile* until used. Needle and container may be autoclaved as many as six times before the discarding of case may become necessary. Truly, *this* needle package pays for itself in time, work, money saved! Order a supply of STERILE DAMASCUS NEEDLES IN NEEDLETAINERS today. Available in the following nine standard needle sizes: 26G x ½, 25G x ⅝, 24G x ¾, 23G x 1, 22G x 1½, 22G x 1, 20G x 1½, 20G x 1, 18G x 1½.

IN 10 SHORT SECONDS • A STERILE NEEDLE LOCKED TO THE SYRINGE

1. OPEN STERILE CASE 2. INSERT SYRINGE, TWIST 3. REMOVE SYRINGE

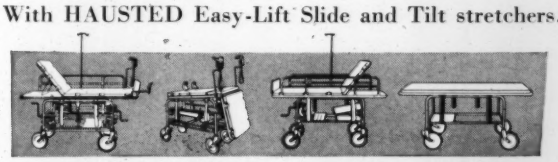
for further information write
MACGREGOR INSTRUMENT CO. NEEDHAM 92, MASS.

ST. LUKE'S SAVES ITS PATIENTS THOUSANDS OF TRANSFERS YEARLY WITH HAUSTED EQUIPMENT

"By placing patients on one of our 12 Hausted Wheel Stretchers when they are admitted to the emergency department, we save thousands of patient transfers annually. Patients remain on the stretchers during examination and treatment until they are placed on beds or released," reports Mr. Kenneth J. Shoos, Superintendent of the Saint Luke's Hospital of Cleveland.

Experience with HAUSTED equipment at St. Luke's Hospital is duplicated everywhere. Patients are placed on HAUSTED stretchers in receiving, then taken to emergency for treatment, on to X-Ray, or surgery, and finally to their beds — all on one stretcher — thus saving patients and staff needless transfers.

With HAUSTED Easy-Lift Slide and Tilt stretchers, even a small nurse can, with the turn of a crank, transfer the heaviest patient to bed with ease and safety.



EASY LIFT CONVER-TABLE STANDARD ECONOMY

Only HAUSTED offers such a large selection of accessories that add to better patient care: Mechanical Height Adjustment Lift, Power Trendelenburg Lift, Shoulder Braces, Special Side Rails, Restraining Straps, Fowler Attachment, Conductive Rubber, Lock and Brake Casters, Arm Rest, Oxygen Tank Holder, Foot and Head Boards, Knee Crutches, Leg Holders and Stirrups.

Ask for a demonstration of HAUSTED stretchers. You'll see their versatility . . . and the complete line of useful accessories. For detailed literature write to . . .

HAUSTED MANUFACTURING COMPANY, Medina, Ohio

surgical privileges. It is true that being a fellow of the American College of Surgeons and a diplomate of the American Board of Surgery are well established criteria for candidates seeking surgical privileges. However, there are well-qualified surgeons who are not fellows or diplomates but do have excellent surgical ability.

Every hospital should have a qualifications committee or credentials committee to consider each applicant desirous of doing surgery. The committee should be composed of senior recognized surgeons who can evaluate candidates from the standpoint of education, training, experience, record of past work and results of treatment. The committee's recommendations should be made to the governing board of the hospital which actually grants the privileges.

There are varying factors to be considered in each individual case, but, generally the candidate should have these qualifications:

1. Be a graduate of an approved medical school.
2. Have an internship of one year or more in a hospital approved for interns.
3. Have a residency in an acceptable hospital of at least three years.
4. Have at least 2 years experience in which he has handled 50 or more cases and in which there have been good results.

—SARAH H. HARDWICKE, M.D.

J&J new design

POST-OPERATIVE STRETCHER

. . . WITH THE NEW 3-POSITION CRANK PERMITTING FASTER, SIMPLER ADJUSTMENT.

Incorporates all the advantages of present models, plus these two optional features:

1 Sponge Rubber Shoulder Rests, to prevent patient from sliding backward when stretcher is in Trendelenburg position.

outstanding features throughout

- Side rails may be elevated ½ way or to full 15" height.
- Mid-position catch *must be released* before rail can be lowered.
- End rail, easily removable, may be positioned at either end or stored under unit.
- Provision for arm rests and restraining straps.
- New Sponge Rubber Shoulder Rests prevent slipping.
- Adjustable 3-position Back Rest.
- Smooth-action elevating mechanism either horizontally, to Trendelenburg, or to reverse Trendelenburg positions.
- Double ball-bearing swivel casters with 10" adjustable, ball-bearing, rubber-tired wheels.
- One caster at either end with dual control locking mechanism.
- Unit electrically conductive throughout.

2 Adjustable Back Rest to allow patient to sit in semi-reclining position (heart attacks, thyroid drainage, X-rays). Wood panel construction permits X-rays of upper body without disturbing patient.

Available: (a) entirely painted; (b) entirely painted, except with stainless steel side rails and stainless steel removable end rail; (c) entirely of stainless.

Nationally Distributed Through Quality Dealers

Sales Representatives In Leading Cities Throughout The Country.

Jarvis AND J&J Jarvis, Inc.

PALMER, MASSACHUSETTS

In Canada: Jarvis & Jarvis of Canada, 1744 William St., Montreal, Quebec

Dependent's medical care

We have several questions regarding servicemen's dependents medical care:

Is maternity care included under this program?

How are eligible dependents identified?

Are unremarried widows and dependent children eligible?

If a hospital does not participate in the local Blue Cross Plan, how is it paid?

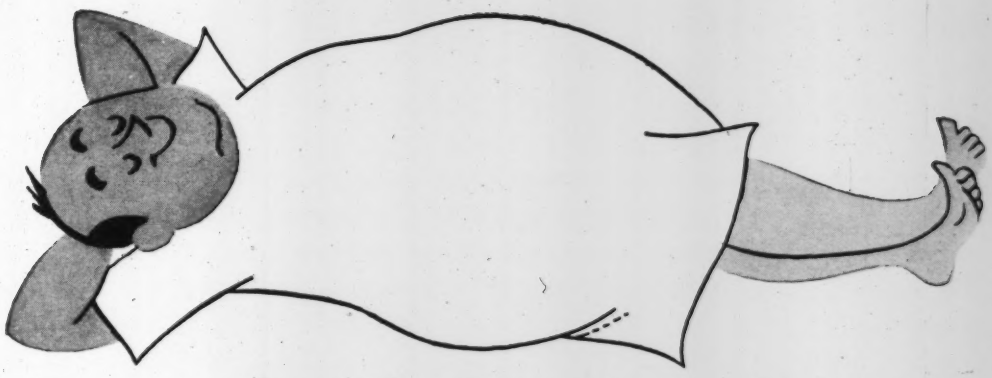
The Dependents' Medical Care Act clearly specifies that the government will be responsible for paying for authorized care rendered to eligible dependents after 12:01 a.m., Dec. 7, 1956. If an eligible dependent is already in the hospital at that time, the government will begin paying for care on the effective date of the act. Maternity care is one of the patient conditions for which care is authorized.

All of the uniformed services included under the act are required to supply eligible dependents with a uniform identification card. These cards must be issued and in use by June 30, 1957. Until that time, dependents will be required to produce existing forms of identification at the time of their admission to a hospital. All of these identification forms are described in detail in the manuals describing the program that have been distributed by the contractor in each state.

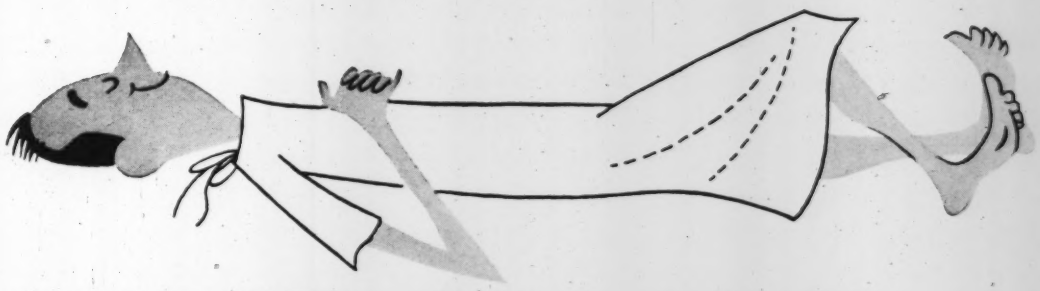
Although unremarried widows and their dependent children are eligible to receive care under the act, such care is not authorized in civilian facilities.

The method of payment to hospitals that do not participate in the local Blue Cross Plan must be worked out in each local area to the satisfaction of the hospitals and the Plan. This is a matter for the Plan and the hospital to decide.

—JAMES R. NEELY



Fat or lean...they both rest better



on a hospital Beautyrest mattress

Whether your patient is a hefty 250-pounder or a 130-pound lightweight—bulgy or bony—he'll rest more comfortably—get the support he needs—on a hospital Beautyrest* mattress.

The restful inside secret is the *independent action* of each individually pocketed Beautyrest coil. Because the coils are not wired together, as with ordinary mattresses, they resist and support *only* in proportion to the pressure put on them. Result: a firm mattress that yields to varying body weight and body contour.

Unlike coil-less type mattresses, Beautyrest never allows a patient to "touch bottom."

Beautyrest mattresses last longer—as proved by actual tests! For example, one of the weak points of an ordinary mattress is the border. Beautyrest has a "crushproof" border so anchored that it supports the weight of a "bed-edge sitter." And, for bed-making convenience, the weight of the mattress holds down sheets firmly.

For patient comfort—for economy and convenience—your best choice in mattresses is Beautyrest!

** Trade-Mark Reg. U. S. Patent Office*

ORDINARY MATTRESS— see how the wired-together coils pull laterally on each other, pulling the whole mattress into a hollow.

BEAUTYREST MATTRESS— in the Beautyrest, only the small, independently pocketed coil, the one pressed, yields — the others remain upright to retain a firm mattress.

SIMMONS COMPANY CONTRACT DIVISION

Beautyrest for hospitals—made only by Simmons

DISPLAY ROOMS: Chicago, New York, San Francisco, Atlanta, Dallas, Columbus, Los Angeles

May we send* you a SAMPLE?

NEW! Absorbent-Knit
HOSPITAL SLIPPERS

PROTECT *patient's feet against* **DRAFTS, FLOOR DISEASES**

Allen A®

1 style fits both: MEN and WOMEN

Proved by 3 years of use with America's leading airlines during transcontinental and transoceanic flights. Now available *for the first time* to hospitals and institutions. Made of soft, long staple cotton knitted to a supple, stretchable fabric. *Guaranteed* to fit every foot. No rights, no lefts. Slips on in 3 seconds . . . fits "snug" for greatest comfort.

SUPER ABSORBENT

Perfect for OB or other ambulatory patients—New Allen-A knitting process gives twice the strength, increases absorbency. Fibers hold foot perspiration and discharges. Prevent spread of harmful bacteria.

LOW COST, LONG WEARING

Most patients forget their slippers and will gladly pay for this service.
More durable, outlasts paper slippers. Low in cost. Attractive blue and white striped pattern.

*** WRITE TODAY**

Please send a FREE sample and prices of New knit Allen-A hospital slippers.

Name_____

Title_____

Hospital_____

Street_____

City_____ **Zone**____ **State**____

ALLEN-A CO. Dept. HO, Piqua, Ohio

accreditation problems

KENNETH B. BABCOCK, M.D.

The material which follows has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director, to provide authoritative answers to questions concerning accreditation. Questions should be sent to the Joint Commission, 660 North Rush Street, Chicago 11, Illinois, or to HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION, for referral to Dr. Babcock and his staff.

Our hospital is to be surveyed in the near future. One of the surveyors is very familiar with our hospital and the problems that face us. Would it be possible for him to survey our hospital?

In most instances the answer would be no. The commission endeavors to rotate surveyors and to avoid sending one surveyor to one district or where he is requested. To have one man repeatedly survey certain hospitals could not help but lead to charges of discrimination or favoritism.

The Joint Commission has no surveyors of its own. The surveyors are employed by the five member organizations: the American College of Physicians, American College of Surgeons, the American Medical Association, Canadian Medical Association and the American Hospital Association. It is the policy of these groups, in cooperation with the commission, to schedule and rotate the hospitals to be surveyed among the member organizations and their surveyors rather than to continue with one organization.

What does the recent edict concerning disaster planning mean to hospitals already accredited and those seeking accreditation? How extensive does the plan have to be to qualify? Is it necessary to have a disaster drill?

The commission makes recommendations, not edicts. The recommendation is meant for all hospitals, accredited or those trying for it. Any hospital not having a disaster plan with drills, however, would be subject to criticism and to the recommendation that a plan be instituted immediately in the hospital. The extent of the plan would be conditioned on the size and facilities of the hospital in question.

Disaster can, and has struck unexpectedly many times in many different places. It is each hospital's responsibility to see to it that it is ready for any possible emergency, whether it be fire, flood, tornado, explosion, or train or auto wreck.

Does the Joint Commission require chiefs of various departments to be board certified?

No. In its Standards the Joint Commission on Accreditation of Hospitals specifically states that the chief of service or department shall be the member of the service or department best qualified, by training, experience and demonstrated ability, for the position. No mention is made in the Standards of board certification or membership.

On the other hand, hospital medical staffs must live up to their responsibilities and appoint the best qualified member, in their estimation, to be chief of the department in question.

What information does the hospital have to supply to the Joint Commission prior to survey?

If a hospital is eligible for accreditation and is to be surveyed, it will receive a statistical survey form 10 to 14 days prior to survey. The form should be filled out and held for the surveyor for his usage.

At the top of the statistical form is a list of hospital reports requested by the surveyor for his study and assessment at the time of survey.

This list and the surveyor's form may be purchased for 50 cents from the Joint Commission for educational purposes and "dry" runs, if a hospital so desires. The commission is located at 660 N. Rush St., Chicago 11, Ill.

weeks?

months?

years?

Improve the prognosis in fractures with "Premarin" with Methyltestosterone

Healing of fractures is often delayed because impairment of osteoblastic activity due to declining sex hormone function causes the bone matrix to atrophy.

Older patients with fractures, particularly of the hip, respond well to combined estrogen-androgen therapy. The prognosis for bone recalcification is good provided treatment is continued for extended periods.*

*Reifenstein, E. C., Jr., in Harrison, T. R.: Principles of Internal Medicine, ed. 2, New York, The Blakiston Company, Inc., 1954, chap. 98, pp. 702, 703.

"PREMARIN"® with METHYLTESTOSTERONE

Excellent preparation for estrogen-androgen therapy

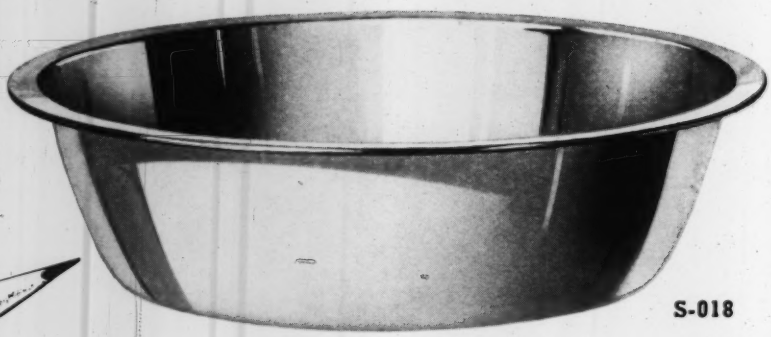
Ayerst Laboratories • New York, N. Y. • Montreal, Canada

Ayerst

5647

POLAR WARE

18 Qt. Stainless Steel Oval Foot-Tub



S-018

. . . a practical, versatile patient-care utensil in a size that you can't get anywhere else

Only Polar Ware offers you an 18-quart stainless steel tub like this one — ideal for foot and arm baths, or for service as an after-birth receptacle. It's unusually sturdy and practical, with a wide, flat bottom that all but eliminates chance tipping. Deeply flared sides check messy, annoying spillovers . . . and an extended flat rolled bead gives nurses or attendants a safe, wide, sure-gripping edge for easier lifting and carrying.

You'll be happy to know, too, that this versatile tub is constructed of heavy gauge stainless steel to give you workhorse performance. Both inside and outside surfaces are finely polished to the attractive, easy-to-clean finish that always identifies Polar Ware. You'll find that it pays to concentrate on this pioneer line of stainless utensils, where 99 chances out of 100, you're sure to find everything you need — and *you know it's right.* Order from your supply house. The best of them carry Polar Ware.

Polar Ware Co.

* 3500 LAKE SHORE ROAD
SHEBOYGAN, WISCONSIN

Merchandise Mart — Chicago 54 Room 1455 | *123 S. Santa Fe Ave. Los Angeles 12, California | *415 Lexington Ave. New York 17, New York | Offices in Other Principal Cities *Designates office and warehouse

Doctor, would it be helpful to you in your practice to know that there is a food available at reasonable prices in the stores the year round having these attributes:

1. High public acceptance as to flavor and palatability—billions eaten annually.

2. One of the best of the "protective" foods with a well-rounded supply of vitamins and minerals.

3. Low sodium—very little fat—no cholesterol.

4. Sealed by nature in a dust-proof package.

5. One of the first solid foods fed babies.

6. Can be easily digested by old folks as well as infants.

7. Can be readily eaten out of hand, in milk shakes, on cereals, or in salads.

8. Can be baked, broiled or fried.

9. Can be used as an ingredient product in breads, pies, cakes and desserts.

10. Useful in bland and low-residue diets.

11. Mildly laxative.

12. May be used in the management of both diarrhea and constipation.

13. Can be used in reducing diets.

14. Can be used in high-calorie diets.

15. Useful in the dietary management of celiac disease.

16. Useful in the dietary management of idiopathic non-tropical sprue.

17. Useful in the management of diabetic diets.

18. Valuable in many allergy diets.

19. Belongs among foods useful in certain acute intestinal infections.

20. A protein sparer.

21. Favorably influences mineral balance.

22. Useful in the management of ulcer diets.

23. One of the easiest of foods to eat or prepare.

FOR THE NAME OF THIS FOOD, PLEASE TURN THE PAGE.

The answer is

BANANAS

If you would like

1. The authority for any of the statements made on the preceding page . . .

2. Additional information in connection with any of them . . .

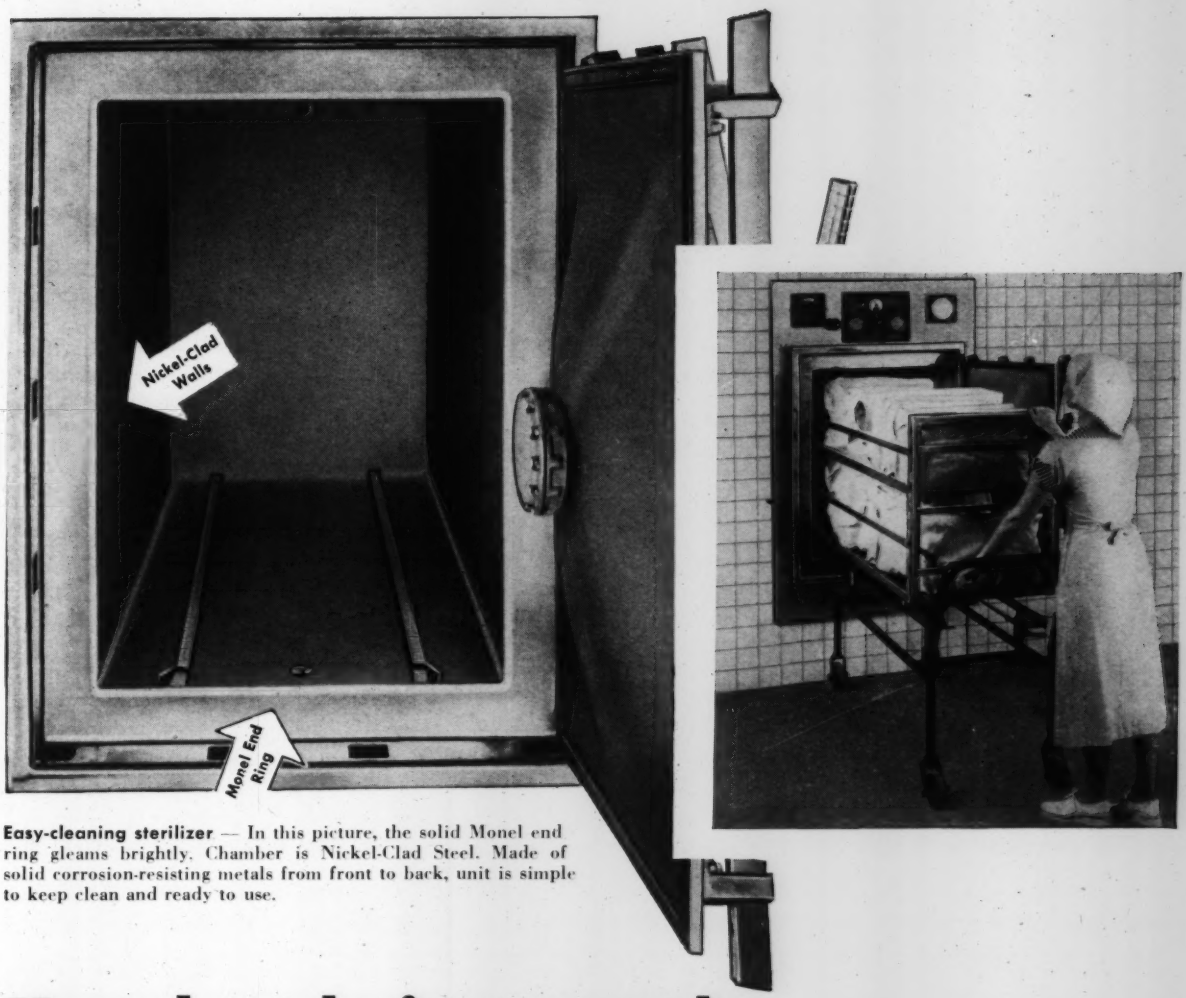
3. The composition of the banana . . .

4. The nutritional story of the banana . . .

5. Information on various ways to prepare or serve bananas . . .

Please feel free to write to

Director, Chemical and Nutrition Research
United Fruit Company
PIER 3, NORTH RIVER, NEW YORK 6, N. Y.



Easy-cleaning sterilizer — In this picture, the solid Monel end ring gleams brightly. Chamber is Nickel-Clad Steel. Made of solid corrosion-resisting metals from front to back, unit is simple to keep clean and ready to use.

Monel end ring guards American's new bulk sterilizer...

Teams up with Nickel-Clad chamber for complete protection against corrosion

If there's one place on a sterilizer that really takes a beating, it's the end ring.

Loading racks and trays jar it. The door closes on it. Locking arms press against it. It endures heat, pressure, corrosive attack.

But this is American Sterilizer Company's new M. E. sterilizer. That means the end ring is Monel* nickel-copper alloy. So it is hard and tough. It stays bright and attractive. Looks as efficient as it is.

Sterilizer sealed against corrosion

American welds the long-wearing Monel end ring to a sterilizing chamber of Lukens Nickel-Clad Steel. Both metals are outstanding for resistance to corrosion by steam, saline and other hospital solutions.

Less work for the staff

These sterilizers are easy to clean. Soap and water or common abrasive cleaning powders keep these sturdy metals bright.

Want more information? Write American Sterilizer Company, Dept. 7-12N, Erie, Pa. They'll gladly send you the catalogue of their new M. E. Series sterilizers.

*Registered trademark

The International Nickel Company, Inc.
67 Wall Street New York 5, N. Y.

INCO TRADE MARK **Nickel Alloys**

Nickel-Clad and Monel sterilizers . . . long life, easy to care for

Murals brighten pediatrics

Colorful murals now delight children and parents alike in the pediatric departments of Monmouth Memorial Hospital, Long Branch, N. J., and St. Jerome Hospital, Batavia, N. Y.

Both pediatric departments are colorfully decorated with objects and characters familiar to children, and contribute to the overall good looks. More important, the cheerful atmosphere helps speed recovery of patients.

The Monmouth mural project was first considered an extravagance, especially since nearly one third of the patients were unable to pay their bills. However, the ingenuity of the housekeeper and the talents of two professional artists made the idea a reality.

Mrs. Lois Milliare, executive housekeeper, originally conceived the idea, but lack of finances prevented any further action. She queried the director of the volunteer group, who suggested she seek the help of two professional artists in the group. The artists responded, the service club provided paint and supplies, and soon the mural-making project was underway.

Designed in a circus motif, the mural includes clowns, animals, and a life-size baby elephant.

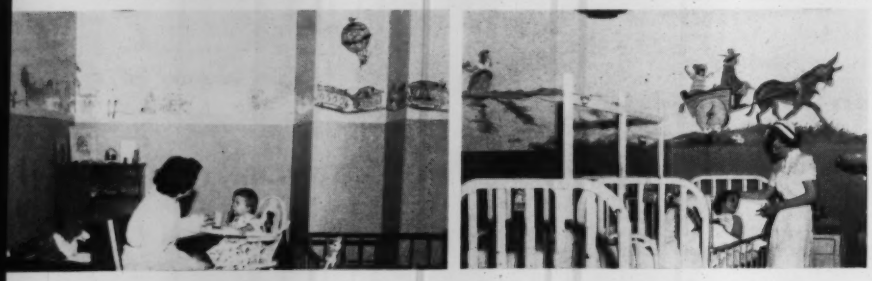
Like Monmouth, St. Jerome Hospital faced financial problems when they sought to redecorate the pediatric department, which was housed in a 35-year-old wing of the hospital.

Sister Mary Cornelia, administrator who sparked the improvement project, sought help from the St. Jerome Guild. A fashion show and dinner dance given by the Guild furnished $2,000 for supplies and new furnishings. Eight artists volunteered their artistic talents.

The new department is the brightest and gayest portion of the hospital. Walls of the patients' rooms, admitting rooms, and examining rooms are covered with favorite childhood characters and scenes from Mother Goose. An express train runs the entire length of the playroom walls.

The institutional atmosphere is gone from the pediatric department, say hospital officials, and the children feel they are among friends. ■

(ABOVE) VOLUNTEER artists put the finishing touches to murals they designed and painted for the pediatric department of Monmouth Memorial Hospital. (BELOW) Familiar Mother Goose characters decorate the walls in the pediatric department of St. Jerome Hospital. Cooperative efforts of volunteer artists and auxiliary members made the mural project a reality.



Medical records librarian

A part-time traveling medical records librarian, who is registered and certified, is successfully handling the work of the medical records department at Columbia Basin Hospital, Ephrata, Washington, says Mrs. Fabiola Torrison, administrator.

Since discharges at Columbia average only 100 to 150 per month, the services of a part-time medical records librarian are felt to be more practical and economical.

The librarian's duties include:

1) Review all records, check to see they are properly signed and completed.

2) Check to see all pathological and consultation reports are in order.

3) See that all outpatient reports are completed, filled out, and properly filed.

4) Check all histories for cross-indexing as to diseases and operation, according to standard nomenclature for physician's reference work.

5) Check cross-indexing on radiology and laboratory departments.

6) Keep staff minute book up to date along with monthly analysis, and attend all scientific meetings.

The librarian reports on the average of once or twice a month, depending on the amount of work to be done. She receives a salary, fare, plus room and board.

The quality, efficiency, and economy of this part-time operation is acknowledged by the hospital staff. It has worked very successfully for four and a half years, and even though a new hospital is being

NOW! A GENERAL PURPOSE GERMICIDE

WESCODYNE® is an excellent detergent as well as a powerful disinfectant. Provides amazing cleaning action as it disinfects. A time and labor saver. Yet cost is less than 2¢ a gallon at the general-purpose use dilution of 75 ppm available iodine.

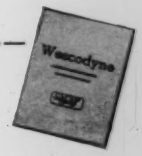
WESCODYNE is the single hospital germicide suitable for disinfecting and sterilization procedures in all hospital areas. It is nonselective. This marked biocidal activity offers a much wider range of effectiveness than solutions containing chlorine, cresylics, phenolics or quaternaries. Germicidal capacity is three to four times that of other germicides as tested on successive kills of seven common organisms.

WESCODYNE is the *first, "Tamed Iodine"® hospital germicide.* Nonstaining. Nonirritating. Nontoxic. Its amber color is a constant indicator of germicidal activity. When this color disappears, germicidal power has been exhausted. Send the coupon for full information, including recommended surgical, nursing and hospital procedures.

LARGEST COMPANY OF ITS KIND IN THE WORLD

WEST DISINFECTING Company

WEST DISINFECTING COMPANY, 42-16 West Street, Long Island City 1, N. Y.
Branches in principal cities • In Canada: 5621-23 Casgrain Ave., Montreal



☐ Please send recommended procedures and full information on Wescodyne.
☐ Please have a West representative telephone for an appointment.

Name.....

Position.....

Mail this coupon with your letterhead to Dept. 39

built, the staff intends to continue the same program. ■

Nurses resume careers

Married nurses with children can now resume nursing duties at Montefiore Hospital, New York, without the usual worries that plague a working mother.

Three years ago, Montefiore opened a nursery school for youngsters of staff members in hopes of luring back to duty some of the well-trained personnel lost to the profession through marriage.

The project has had some surprising results. Mrs. Judy Gutman, the school's director, points out that only one of the 15 mothers who have children in the nursery had previously worked at Montefiore. The others were drawn to the hospital because it offered help in taking care of their preschool age children.

Primarily a baby-sitting service in its early days, the school now has a much more expanded and defined educational program. The staff includes two group teachers, one assistant, two part-time cooks, a secretary, and a janitor. In setting up a school program, Montefiore sought help from the Jewish Association for Neighborhood Centers. This agency took over sponsorship of a full-fledged school and selected the director. It now acts in a supervisory capacity. Like any other day-care center in New York, the school must meet licensing requirements of the Department of Health of the City of New York.

The school day is long—usually from 7:45 a.m. to 4:30 p.m. The long hours of separation between child and parent present problems. To avoid emotional upsets, the school emphasizes family ties. The children are made to feel they are part of a community shared by them and their mothers. This is done by planning trips within the hospital—to the switchboard, the mail room and the animal room. The child loses the feeling of isolation by becoming familiar with this second world.

Mothers are welcome to spend free time with their offspring, and fathers, too, are encouraged to visit. Parent-staff meetings are held once a month, and Mrs. Gutman reports, from half to three fourths of all fathers attend.

One important service: breakfast is served each morning. This gets the children off to a better start since most of them are too rushed to eat much at home, says Mrs. Gutman.

Has the project been successful? The first year, enrollment totaled 7; today, 20 children attend the nursery school. Some 15 nurses have been able to resume their nursing careers.

What about the children? Do they benefit? "Yes," reply enthusiastic mothers. One mother says this: "Linda is an only child. Here she is learning to get along with other youngsters."

Another parent reports: "I used to wonder if the person in charge at home was really preparing proper meals, and managing outdoor play and naps. With the school, my mind is at ease."

The nursery school has helped solve one of Montefiore's most pressing problems: how to get experienced nursing personnel back on the job. ■

fast-acting therapy in

HYLAND

NORMAL SERUM

ALBUMIN

(HUMAN)

25% SOLUTION • HEPATITIS-FREE • READY FOR IMMEDIATE USE

The principal fluid-binding component of human blood—ready for immediate infusion without delay for reconstitution, grouping, typing or crossmatching. Draws 3½ times its volume into vascular circulation within 15 minutes when patient is not dehydrated. Supplied: Normal Serum Albumin (Human), Salt-Poor, 25% solution—*20 cc. vial* (5.0 Gm. albumin) for syringe administration; *50 cc. vial* (12.5 Gm. albumin) with administration set.

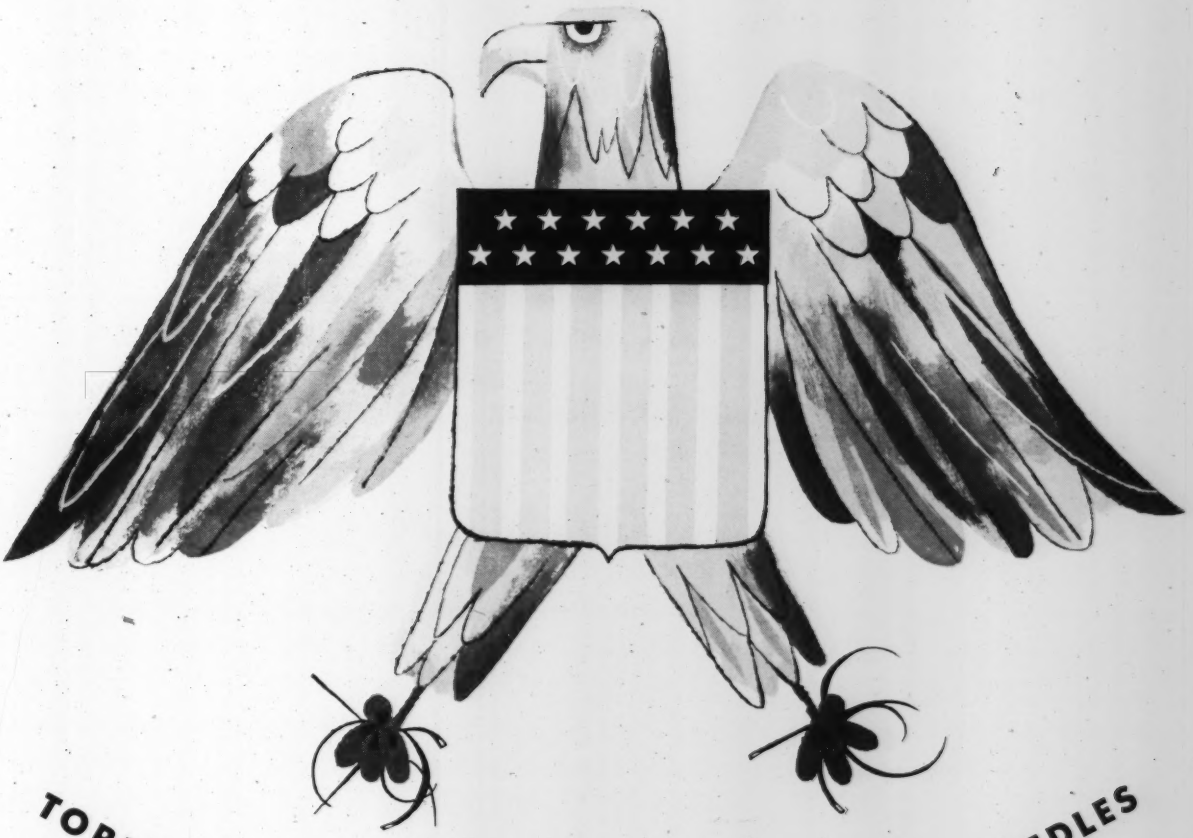
Hyland Normal Serum Albumin is also supplied as a 5% **Solution in Saline,** providing all fluid needed for full osmotic effect—*250 cc. bottle* (12.5 Gm. albumin), with administration set.

Send for shock-therapy chart comparing advantages and disadvantages of whole blood, liquid plasma, dried plasma, 25% albumin, 5% albumin in saline, and dextran—all of which are available from Hyland.

Hyland

HYLAND LABORATORIES

4501 COLORADO BLVD., LOS ANGELES 39, CALIF.
252 HAWTHORNE AVE., YONKERS, N.Y.

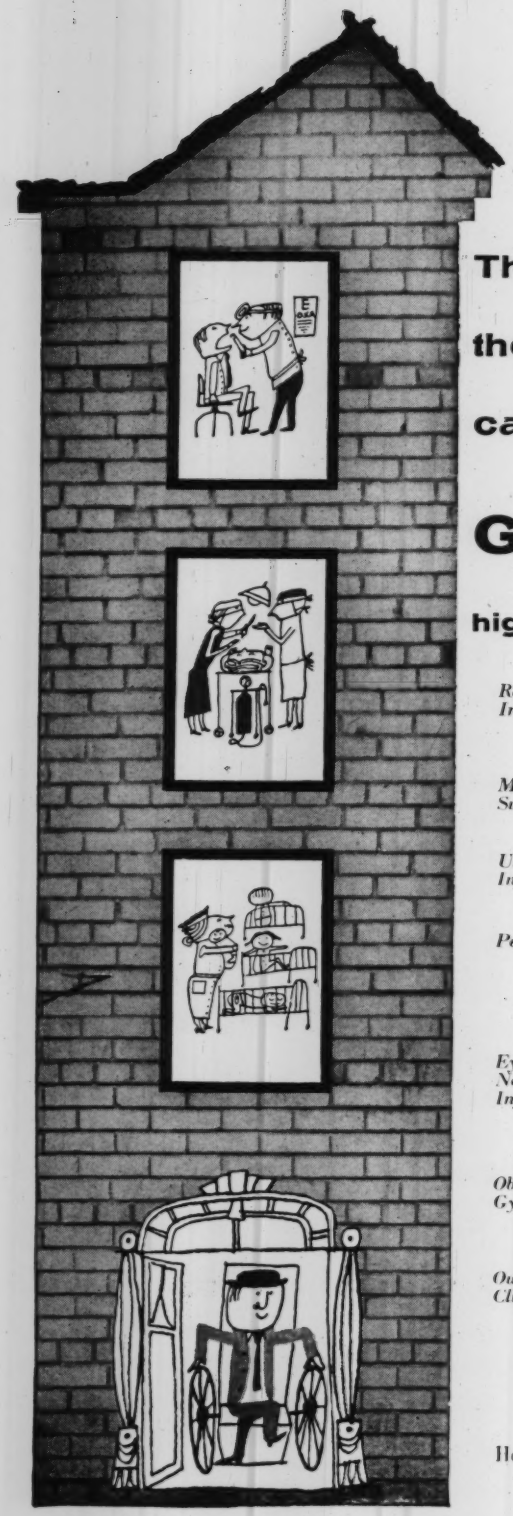


TORRINGTON STAINLESS STEEL SURGEONS NEEDLES
ARE MADE IN AMERICA TO HIGHEST PROFESSIONAL STANDARDS

Torrington Stainless Surgeons Needles are accurate . . . uniform . . . dependable. All types and sizes are immediately available from your surgical supplies dealers. For quality surgeons needles, be sure to specify TORRINGTON — the finest surgeons needles in the world!

THE TORRINGTON COMPANY
Torrington, Conn.

Torrington's 91st Year of Dependable Service



Throughout the hospital there are more and more calls for

GANTRISIN *Roche*

highly soluble, single sulfonamide

Respiratory Infections	tablets, 0.5 Gm each
Meningitis Surgery	ampuls, 5 cc (2 Gm) and 10 cc (4 Gm)
Urinary Infections	tablets, 0.5 Gm each
Pediatrics	pediatric suspension (raspberry-flavored), and syrup (chocolate-flavored), containing the new, tasteless Gantrisin (acetyl)
Eye, Ear, Nose & Throat Infections	ophthalmic solution, 4%, ophthalmic ointment, 4%, ear solution, 4%, and nasal solution, 4%
Obstetrics & Gynecology	vaginal cream, 10%, in white vanishing cream base
Outpatient Clinic	tablets, 0.5 Gm each

Gantrisin®—brand of sulfisoxazole
Gantrisin® (acetyl)—brand of acetyl sulfisoxazole

Hoffmann - La Roche Inc • Roche Park • Nutley 10 • N. J.

HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—action in a health crisis

Scientists have found a vaccine against poliomyelitis. There is hope for a similar achievement in cancer. But there is no hope for a vaccine against one of our major health problems—traffic accidents.

When the final tragic figures for 1956 are tabulated, the death toll will probably go over 40,000, the highest in history. The National Safety Council has calculated that for every death there are 35 injuries causing at least one day's disability. Thus, the injury total during 1956 will be in the shocking neighborhood of 1,400,000.

Research may help build even safer roads and even safer automobiles. It is unlikely that research will build a truly safe driver. This is the role of education and re-education.

An active part in civic efforts to reduce this ghastly carnage must be played by hospital administrators. It is not enough for hospitals to be prepared to care for the bodies broken in traffic accidents.

Hospital leaders, as health leaders, must go beyond their institutions and bring their informed influence to bear on sound traffic safety programs.

The *Journal of the American Medical Association* has called upon physicians to project themselves vigorously into the traffic crisis. A similar responsibility lies upon those in the hospital field.

—survey of fringe benefits

Most hospital salaries have grown increasingly competitive with those of industry. Like industry, many hospitals now have some kind of fringe benefit program. These benefits, when linked with salaries, usually form the backbone of a hospital's personnel policy. Without them, most hospitals would find it impossible to attract new employees and to retain present staff.

Fringe benefits are also far too important from a cost standpoint to be taken for granted. How much do they cost? How effective are they? How inclusive? The answers to these questions should be based on study, not speculation.

Greenville (S.C.) General Hospital had to make such a study before it could decide whether it could afford to continue providing comprehensive fringe benefit coverage and at the same time increase salaries. The hospital has analyzed the costs and adequacy of its fringe benefit program. The article on page 44 of this issue of **HOSPITALS**, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION, describes how the data were gathered and the preliminary conclusions drawn from them.

—Blue Cross Association support reaffirmed

The most significant development for years in the Blue Cross movement is the reorganization of the Blue Cross Association into the national enrollment arm of Blue Cross.

The AHA's Council on Prepayment Plans and Hospital Reimbursement, the Coordinating Committee and the Board of Trustees have considered the reorganization carefully. The position of the Association is published in "Official Notes" on page 87 of this issue of **HOSPITALS**.

In summary, it is the opinion of the American Hospital Association that the reorganization will not affect the basic relation between hospitals and Blue Cross Plans at the local level.

The Board noted that the reorganized structure of the Blue Cross Association establishes a mechanism for the further extension of the voluntary system of nonprofit prepayment for hospital services. The Association reaffirms its approval of the Blue Cross Association and urges hospitals to assist in implementing programs that may be developed by the Blue Cross Association.

must the hospital be a yes

by ADDISON M. DUVAL, M.D.

Dr. Duval presents an eight point discussion upholding the viewpoint that a mental hospital superintendent must be a physician with specific training and experience in hospital psychiatry and preferably one with training in scientific management. He outlines the benefits of such an administrator to mental hospital patients and personnel, and to the community.

IN RECENT YEARS the question of utilizing lay superintendents for mental hospitals has been raised with increasing frequency. Aggressive action on this question by any organized group could threaten the very foundations of mental hospital functioning as it has developed in America. No such action has yet developed but the potential exists. Therefore, every person who is interested in mental health—whether professional or nonprofessional, medical or nonmedical, should carefully consider the pros and cons of this question. As Hutchins[1] has said "From the clash of opinion truth emerges and the human race advances."

I am convinced that mental hospital superintendents must be physicians who are specially trained for the job. The reason for this opinion are presented herein. This conviction is fortified by more than 25 years experience in a large mental hospital where the writer has had demonstrated repeatedly the values—to the patient, to the hospital, and to the community—which are inherent in the physician superintendent plan.

1. Physician Superintendents Over More Than a Century Have Been Largely Responsible for Advances in Mental Hospital Therapy in the United States.

The history of the development of mental hospitals in America is largely the history of the accomplishments of the physicians who were the superintendents of these hospitals. The records of early American hospital psychiatry are the records of such men as Samuel Woodward of Worcester (Mass.), Charles Stedman of Boston, Francis Stribling and John Galt of Virginia, Amariah Brigham of Utica (N.Y.), Isaac Ray of Maine, John Butler of Hartford (Conn.), Thomas Kirkbride of Pennsylvania, together with Luther Bell, Pliny Earle, William Awl, Nehemiah Cutter and Samuel White. These are the "Original Thirteen" physicians, all superintendents of mental hospitals, who in 1844 founded what is now the American Psychiatric Association.

In those early days, the requirement that the superintendent *must* be a physician was sometimes written into enabling legislation. This was true in the case of Saint Elizabeths Hospital in Washington, D.C. (1855) when the U.S. Congress wrote in the Act establishing the hospital that, "The superintendent shall be a well educated physician, possessing competent experience in the care and treatment of the insane; - - ."

This requirement stands unchanged today. As an example of how well this has worked, one need only mention the present superintendent of Saint Elizabeths Hospital, Winfred Overholser, and his immediate predecessor, the late William Alanson White, both of whom have received most of the honors that American and international psychiatry can confer and whose hospital has always been a leader in its field. Other modern counterparts of the "Original Thirteen" are such administrators as William A. Bryan, Earl Bond, Karl Menninger, Leo Bartemeier, Francis Braceland and Walter Barton. The records of these men are largely synonymous with the records of their hospital stewardships. Without their type of leadership the mental hospitals of America could not have reached their present day accomplishments in psychiatric therapy.

2. Those Mental Hospitals Which Are Today Recognized as the Best in the Country Are All Administered by Physicians.

The practice of having physicians as superintendents of mental hospitals is followed almost universally in the United States and Canada and without exception the best mental hospitals consistently follow the practice. In these leading hospitals no one would think of suggesting a change to a lay superintendent. Both the commu-

(Continued on page 37)

Addison M. Duval, M.D., is assistant superintendent of Saint Elizabeths Hospital, Washington.

superintendent physician psychiatrist?

by ROBERT H. KLEIN and PAUL E. FELDMAN, M.D.

Nonmedical personnel with proved administrative ability are desirable candidates for mental hospital superintendents, say authors Robert Klein and Dr. Paul Feldman. Qualified laymen can be trained to do an effective job when a medical superintendent is unavailable. They point out that certain aspects of a psychiatrist's training may hinder his performance as an administrator.

THE VERY DISCUSSION of the topic, lay vs. medical administration in psychiatric hospitals, indicates a refreshing and progressive attitude on the part of the American Psychiatric Association.

Existing APA standards for psychiatric hospitals have always provided that the superintendent, manager, or director shall be only a doctor who has qualified as a diplomate of the American Board of Psychiatry and Neurology with at least five years' experience in a mental hospital, three years of which shall have been in a responsible position involving administrative duties.

However, the specific title of the discussion—lay vs. medical administration—prejudices the case in favor of the medical administrators even before the discussion begins. Why? Because according to the dictionary "lay" is described as meaning "pertaining to laity; nonprofessional; *inexperienced*." If the subject then were rephrased as inexperienced vs. medical administration in psychiatric hospitals, there would be no necessity for discussion at all. This is much more than a matter of mere semantics. The choice of title by the committee inadvertently, but accurately, reflects the prevailing APA attitude that everyone other than a medical administrator is technically inexperienced.

Since such a conclusion is unsatisfactory, please permit the title of this discussion to be rephrased nonmedical vs. medical administration in psychiatric hospitals. We would like to define administrator as one who directs the activities of other persons and undertakes the responsibility for achieving certain objectives through these efforts.

The function of a psychiatric hospital is the utilization of every treatment available for restoring psychiatric patients to health or helping them improve sufficiently to be able to leave the hospital at the earliest possible moment, and short of such success, aiding them to live as nearly normal lives as possible within the institutional setting.

ADMINISTRATIVE SKILLS

If the above description of an administrator is acceptable, then it can be said that successful administration appears to rest on three basic skills, namely, technical, human and conceptual. (This analysis of administration leans heavily on the work done by Robert L. Katz of the School of Business Administration of Dartmouth College.)

Technical skill implies an understanding of, and proficiency in, a specific kind of activity, particularly one involving methods, processes, procedures, or techniques. Most vocational and on-the-job training programs are primarily concerned with developing this specialized technical skill.

Human skill may be defined as the executive's ability to work effectively as a group member and to build cooperative effort within the team he leads. Human skill is primarily concerned with working with people, whereas technical skill is primarily concerned with working with "things." The person with highly developed human skill is aware of his own attitudes, assumptions and beliefs about other individuals and groups. He is able to see the usefulness and limitations of these feelings. By accepting the existence of viewpoints, perceptions and beliefs which are different from his own, he is skillful in understanding what others really mean by their words and behavior. He is equally skillful in communicating to others, in their

Robert H. Klein is a member of the board of directors, Michael Reese Hospital.
Paul E. Feldman, M.D., is director of research and education at the Topeka State Hospital, Topeka, Kans.

Their article was adapted from a panel discussion presented at the May 1956 meeting of the American Psychiatric Association.

contexts, what he means by *his* behavior. *Human* skill must be naturally developed and unconsciously, as well as consistently, demonstrated in the individual's every action. It must become an integral part of his whole being.

By *conceptual* skill is meant the ability to see the enterprise as a whole. It includes recognizing how the various facets of the organization depend on one another and how changes in any one affect all the others.

This skill extends to visualizing the relationship of the individual hospital to the system of which it is a part, to the community and to the medical, social, economic and political forces of the state and of the nation as a whole. Recognizing these relationships and perceiving the significant elements in any situation, the administrator is then able to act in a way which advances the over-all welfare of the total organization.

Sometimes conceptual skill is referred to as "creative ability." Chester I. Barnard, former president of the New Jersey Bell Telephone Company and a great student of administration, has said, "The essential aspect of the executive process is the sensing of the organization as a whole and the total situation relevant to it."

By using the *conceptual* skill as an ability to transfer knowledge into action, it's possible to distinguish between the three skills, technical, human and conceptual, even though conceptual skill embodies consideration of both the others.

The relative importance of the three skills seems to vary with the level of administrative responsibility. At lower levels, the major need is for technical and human skills. At higher levels, the administrator's effectiveness depends largely upon human and conceptual skills. At the top, conceptual skill becomes the most important of all for successful administration. This three-skill approach emphasizes that good administrators are not necessarily born. They may be developed—although frequently only after much effort over a considerable period of time.

The type of mental hospital administrator under discussion here is not of the "chief clerk" or "business manager" variety, found in some state hospitals. Instead, we have in mind a lay person with minimally the following qualifications:

1) A master's degree in business, hospital or public administration or some related field.

2) A minimum of eight years' experience in administrative functions, five years of which should be in one of the medical or allied fields and three of those years in a mental hospital setting in capacities such as administrative assistant, assistant administrator, etc.

It is important to point out, too, that graduate training in psychiatry is usually accomplished without ever obtaining any theoretical or practical experience in business administration. Psychiatric residencies just do not offer courses such as cost accounting, budgeting, food service, maintenance, repairs.

PSYCHIATRISTS' FAILURES

It is of much more than passing interest that especially among psychiatrists, administrative psychiatry is of relatively low prestige. Stanton and Schwartz in their recent book, *The Mental Hospital,* point out that the only claim to prestige of administrative psychiatry, in the face of its glittering brother—psychotherapy—is that it is unavoidable and practical. They further state that among psychiatrists "administration has become an intellectually and scientifically arid field."

Most psychiatrists acting as administrators give lip service to the idea of the "team approach." As a matter of fact, they frequently fail to realize that the mere placing together of a group of individuals does not constitute the making of a team. Furthermore, the psychiatrist acting as an administrator all too frequently fails to delegate authority. He finds it impossible to carry out the undelegated tasks merely because he has saddled himself with the responsibility for more functions than it is possible for any one human being to handle. Thus, others either take over according to their own ideas or some functions are left undone—all of which results in confusion and inefficiency.

The inability of some medical administrators to delegate authority and responsibility is understandable. The psychiatrist, being a medical man, is accustomed to gathering facts upon which he makes a decision to the best of his ability. It is contrary to his training and practice to delegate this responsibility. True, he may ask advice from consultants, but the final decision is his to make. Unfortunately, when this attitude and practice is carried over into administration, he is disinclined to delegate authority, to allow others to make decisions, and in general he feels ill at ease in the role of one who stimulates others to think and make decisions.

GROUP ACTION NEEDED

Paradoxical as it may seem, there are aspects of psychiatry that the psychiatrist has to unlearn when he assumes the role of a medical administrator, i.e., a basic difference between the administrative and the psychiatric approach to people. This often creates difficulties for the psychiatrist when he functions as an administrator, because administrative thinking is group-centered rather than individual-centered. The psychiatrist is more inclined to isolate the individual from the group and act towards the individual without considering the effect of his action on the total group. The administrator's role is to influence the behavior of people in groups so that they will work together cooperatively in defining and accomplishing group goals. This function can be performed by other than medical men.

The lay administrator concerns himself with the individual's ability to perform his job and get along with his co-workers. This concern does not extend to an exploration of deeper motivations and a search for neurotic tendencies. The psychiatrist, being trained to think in terms of personality pathology, may reduce his administrative effectiveness because he does not restrain his tendency to search for personality defects in his employees—even when they are performing satisfactorily on the job. It is all too common for an employee to feel that he is being treated as though he were a patient rather than an employee—and for patients to feel like they

are being treated as employees.

Dr. Esther Lucille Brown, in a recent book, *From Custodial to Therapeutic Care in Mental Hospitals,* points out that even within hospitals that have a relatively high level of administrative competence, there are many roadblocks to finding therapeutic goals, which might be removed if the administrators had perceived them not as merely individual barriers but as signs indicating basic organization weakness.

NONADMINISTRATIVE FUNCTIONS

The usual practice in mental hospitals today is to "promote" or "demote" a psychiatrist from the clinical fields to administrative fields without any special preparation for the performance of his new duties. Most hospital superintendents have advanced from ward physician to clinical director to superintendent, during this transition doing less clinical psychiatry and more administration.

There is the all too frequent tendency of medical administrators to utilize a substantial portion of their time on nonadministrative functions with the result that administration suffers. The results of a 1953 survey by the American Hospital Association stated that in 237 reporting "mental and allied governmental hospitals" (amongst the U.S. total of 546), the administrators spent only 47 per cent of their time on administrative matters. More than one-half of their time was spent on other activities, of which direct medical care represented the biggest segment. Compare this with 90 per cent of their time spent on administrative duties by the directors of all short term hospitals with 250 beds and over. In the typical large mental hospitals, administration must suffer if

(Continued on page 98)

must the mental hospital superintendent be a physician psychiatrist?

YES

(Continued from page 34)

nity and the staff would offer violent objections. Only where a hospital has a "weak" physician superintendent, and consequently, poor administrative function, does the alternative suggestion for a lay administrator find support. Study will show that the trouble here is with the specific person and not the principle or practice.

3. The Administrator of a Mental Hospital Is so Intimately a Part of the Therapeutic Program that a Physician Superintendent Is Mandatory.

The administrator of a mental hospital is quite different from that of a general hospital. The mental hospital of today is in essence a therapeutic community where every facet and facility, every plan and policy, every staff function—both professional and nonprofessional—and every management action is adopted to meet the treatment needs of the patient. This conception of the mental hospital as a therapeutic community has grown from specific investigations into the therapeutic value to the patient of all that goes on in the hospital, the feelings that accompany such action and the emotional support which follows such purposive relationships. Information is being slowly developed about the possibility of structuring this climate or body of relationships in accordance with the therapeutic needs of the patients so that recovery may occur in much less time than was formerly necessary. How can anyone but a physician properly assume this broadly based therapeutic responsibility? The lay administrator has no preparation for such function or responsibility and only the psychiatrist has this qualification.

4. Use of the Lay Superintendent Violates a Cardinal Principle of Modern Management.

The laws of most of the states give full responsibility for the treatment and care of the hospitalized mental patient specifically to the superintendent of the hospital. While he may seek and receive professional, as well as other advice from the members of his staff, he retains the final responsibility for all treatment decisions made and may be—and is—held fully accountable for his stewardship. It is scarcely conceivable that one who is not a physician can be given — or would accept — such great responsibility.

To assert that a lay superintendent would not seek or accept such medical responsibility but would delegate it to trained psychiatrists makes of him something less than a superintendent. It also violates a cardinal principle of good management in that it creates two conflicting sources of authority—that associated with the lay administrator and that associated with the physician. In any organization there should be one ultimate head who carries final responsibility and authority whether inherent or delegated.

5. Other Deficiencies in Lay Superintendent Plan.

It seems probable that those who recommend lay superintendents are impressed with the advances which in recent years have been made in the field of administration of general hospitals, and they believe that this type of experience is good preparation for mental hospital administration. It is true that we have good superintendents of general hospitals who are not physicians. These men have usually been well and specially trained for their jobs. Nevertheless, certain administrators believe that medical training is also advisable for superintendents of general hospitals.

Indicative of some basic emotional conflict in lay superintendents of general hospitals toward physicians, Dichter, director of the Institute for Research in Mass Motivations, Inc., said about a survey of general hospital-patient relationships:

"Our field survey has shown that when hospital administrators were asked about the doctor relationship they almost always answered with glowing descriptions. Yet further investigation as often as not showed a deep undercurrent of conflict. Inevitably the tone of such conflict transmits itself within and outside the hospital."

There is real danger that this basic conflict would also cause

much administrative difficulty in the mental hospital operation. Particularly might this be true concerning the allotment of hospital funds to the separate administrative and medical functions. A non-physician mental hospital superintendent might well consider, e.g., the needs of the hospital industries as a priority budget item over the need of new drugs or other expensive treatment measures for the patients.

6. Training in General Hospital Administration Does Not Qualify for Mental Hospital Administration or Vice Versa.

In growth and development the science of mental hospital administration has lagged behind that of general hospital administration. But this does not mean that the extension of general hospital administrative practices to mental hospitals would be effective. More differences than similarities exist between the two and preparation for one does not qualify for the other. Special preparation for the mental hospital administrator must be developed. The American Psychiatric Association recognizes these facts and special efforts are now being made to set up approved training in mental hospital administration through organized university courses and supervised clinical experience. It has been my good fortune to attend intensive courses in scientific management given by the American Management Association and I firmly believe such courses might well be required for future physician superintendents of mental hospitals. The principles, skills and tools of the science of management apply equally to hospitals as to industry and the insight and understanding which these could provide to the mental hospital superintendent would be of inestimable value.

However, let us not be deluded. Such courses can not of themselves replace the more basic psychiatric training of the superintendent. Integration of the two courses of training is the ideal and such integration is not at all impossible or even difficult. But such integration would not eliminate the need for an administrative assistant to the superintendent who would directly supervise the everyday work of the administrative section of the hospital. Such assistant is much needed but as an assistant and *not* as superintendent. The routine everyday function of the administrative section should not be carried directly by the superintendent, for he needs his time for the over-all supervision of his therapeutic community—the hospital. The superintendent must set the "climate," control the function, and give dynamic leadership to all employees of the hospital if the best treatment and care of patients is to be assured. The details concerning treatment and administration are the responsibility of his assistants and should be so delegated.

7. Accepted Standards for Mental Hospitals Require Superintendent To Be a Physician Trained in Mental Hospital Work.

Sound principle dictates that those people with the greatest knowledge concerning a special function should set the standards for that function. This practice is followed by most professional groups, such as teachers, lawyers, psychologists, nurses and physicians. Those who know most about mental hospitals are the physicians who treat the patients and administer the hospital. The standards approved by the American Psychiatric Association are the only recognized standards for mental hospitals. These standards[5] require that the superintendent be a physician experienced in mental hospital work. In the preparation of these, when the writer was chairman of the standards committee, more than 100 American and Canadian psychiatrists experienced in mental hospital administration were consulted and they unanimously supported this requirement. Such mental hospital authorities as Anderson,[6] Baganz,[7] Linn,[8] and others consistently support this principle.

8. The Hospital of the Future as a Structured Social Entity.

In recent years there has been much improvement in the standards of care and treatment in mental hospitals, and the leadership in this movement has largely come from physician superintendents. They are still the backbone of the modern treatment of the mentally ill. However, assistance from other professions allied to psychiatry is gradually developing as researchers present new knowledge. The social scientist in particular is leading the way in a cooperative effort with the psychiatrist to develop understanding that will permit the administration of both general and mental hospitals to be carefully structured and carefully attuned to both the physical and the psychological needs of the patients. While this effort is still in the exploratory stage, some hospitals are even now operating under such principles and they report promising results. Closely related are new concepts concerning the importance of voluntary patient participation in the everyday activities of the hospital, including the rules of conduct of patients, relationships of patients to employees, patient privileges, patient self-government and even patients' responsibility for each other's behavior. This general plan quickly spreads to the general administration of the hospital. The administrator must understand and be able to guide these dynamic forces for the good of the patient and the hospital, and only the psychiatrist is today prepared for this job.

In conclusion, a development wherein lay superintendents would administer mental hospitals is quite remote in the foreseeable future. If a shortage of trained physician superintendents should develop by reason of too low salaries, too low hospital standards, diminished job satisfaction or for other reasons, then and then only might the lay superintendent encroach on this medical field. In my opinion such an unfortunate event would result in a lessening of the chance of recovery for the hospitalized mentally ill who today constitute our most serious health problem in America. ■

BIBLIOGRAPHY

1. Hutchins, R. M. The administrator reconsidered. Hospital Management, 81:63 Jan. 1956.
2. Hurd, H. M. The Institutional Care of the Insane in the United States and Canada. Baltimore, The Johns Hopkins Press, 1916.
3. Kirsch, E. When doctor turns administrator. Modern Hospital, 64:69 June 1945.
4. Dichter, E. The administrator sets the tone. Modern Hospital 84.59 Feb. 1955.
5. Standards for Hospitals and Clinics. Wash. D.C., Am. Psych. Assoc., 1956.
6. Anderson, R. C. A function of administration: psychiatric treatment. Bulletin of the Menninger Clinic, 19:173 Sept. 1955.
7. Baganz, C. N. The growing science of mental hospital administration. Am. J. of Psych., 110:161 Sept. 1953.
8. Linn, L. A Handbook of Hospital Psychiatry. New York Int. University Press, 1955.

insurance coverages needed during construction

by SISTER ELISE, S.C.

As soon as plans are begun with the architect, the hospital should establish an insurance section in the contract to establish the duties of all parties concerned and the exact manner in which insurance situations are to be handled. The types and extent of coverage that owner and contractor need for adequate protection should be carefully considered.

FEW INSURANCE buyers are fully acquainted with the hazards of contracting for new construction. Almost as soon as plans are begun with the architect, an insurance section should be included to establish the duties of all parties concerned and the exact manner in which insurance situations are to be handled.

The owner should consider the type and manner of construction, for they have direct bearing upon property insurance rates. By making certain that the type of construction meets with approved standards of fire insurance underwriters, sufficient money can often be saved in fire insurance premiums to more than amortize, over a period of years, any small additional expenditure that might be required at the outset to bring the proposed building up to recognized standards. For example, a building might merit "superior" rate treatment by the installation of automatic sprinklers in such areas as boiler rooms, storerooms, stairwells, etc. The cost of this installation at the time of initial construction is very small compared to the future outlay in fire insurance premiums.

The proper procedure is to consult with qualified insurance personnel when the plans are being drawn. They can offer suggestions and make actual cost comparisons of the fire rates which will result from various situations. It is not intended to infer that the insurance cost should necessarily change the type of construction contemplated; however, it should be a factor in the over-all evaluation. Safety is a factor of much greater importance. The same factors that would decrease insurance rates would result in better protection for patients and personnel.

INSURANCE SECTION

Establishing the insurance section in the general conditions will not, in itself, make certain that proper procedures are followed. Contractors and subcontractors should be required to prove that they have complied with specifications. In the insurance phase of the operation, the contractor should furnish certificates of his insurance to the owner. It should be stated in the general conditions:

1. That the contractor should not commence work under the contemplated contract until he has obtained all of the insurance required, and until the owner has approved the certificates of insurance stipulated.

2. That the contractor should not allow any subcontractor to com-

---

Sister Elise, S.C., is treasurer general of the Sisters of Charity of Cincinnati, Mount St. Joseph, Ohio, and a former member of the American Hospital Association Committee on Insurance for Hospitals. This material will be included in the additions to the AHA *Manual on Insurance for Hospitals*, which will be published and distributed to member hospitals.

mence work on his subcontract until all similar insurance required of the subcontractor has been approved and backed with similar certificates of insurance.

It is understood that owner's approval of the insurance in no way shall relieve or decrease the contractor's liability.

Insurance against physical damages to structures is often best handled by the owner. The normal perils insured against are fire, lightning, extended coverage, vandalism and malicious mischief. In some areas it would be well to consider special coverages, such as earthquake. The owner should agree to effect and maintain these coverages upon the entire structure and upon all materials in or adjacent thereto and intended for use thereon. This insurance should also include loss to temporary buildings, form work, scaffolding, equipment, materials and supplies on the site. Anything stored off the site should be understood to be stored at the contractor's risk, and the contractor should provide separate insurance to cover such items.

Insurance should be in the owner's and contractor's names to cover the interest of each as they may appear. Normally all premiums would be assumed by the owner, unless unusually large values are present in special tools and equipment. In this case, the contractor might be asked to participate in the cost.

There are several ways of writing builder's risk insurance: a reporting form, open form with endorsements at intervals, or the "completed value form." The latter requires the minimum amount of work and precludes the possibility of failing to obtain sufficient insurance to cover a structure's value at any given time. Here again, the advice of the owner's insurance counsel is recommended.

CONTRACTOR'S EMPLOYEES

The contractor's employees should be the concern of the contractor, but the owner should make certain that the contractor has in effect and maintains workmen's compensation and employers' liability insurance for his employees engaged in work on the contemplated project. In case any such work is sublet, the contractor shall require the subcontractor to provide workmen's compensation and employers' liability insurance for all of the latter's employees.

CONTRACT BIDDING, BONDING

Under current conditions, contractors are bidding tighter and closer than ever before, because of the great competition that has developed in the building lines. This tighter bidding is good for the owner who is paying the bills, but it is, in a sense, bad for the construction business for there has been a marked increase in failures in the construction field. As of 1955, only 2 per cent of the contractors now in business have lasted more than 20 years, and only 7 per cent last 5 years.* All of the contractors have not failed; many have retired or gone into other businesses; but it is worthy to note that many fine contracting companies, with fine reputations, do get into financial difficulties that they cannot overcome.

The prudent owner should consider contract bonding as a *must* on any sizable job. It is best to secure the broadest possible form of contract bond, which is a combined performance and payment bond. This bond assures the owner faithful performance of contract and payment of all labor and material bills. The cost of a bond, covering 100 per cent of the contract price, is no higher than one covering 50 per cent, for the surety companies feel that the exposure to the company is the same for 50 per cent of a risk as for 100 per cent. The companies have found that rarely does a loss exceed 50 per cent of the contract price, so they can offer the 100 per cent bond without increasing their risk. In any event, premiums are computed on contract price and not on the amount of the bond.

The sooner work is started in qualifying contractors, the better it is for all concerned. It is sound procedure to prequalify contractors by investigating their financial status prior to extending invitations to bid, or by requiring them to furnish bid bonds at the time of bidding, in which case the surety company undertakes the financial investigation.

There are two schools of thought as to the mechanics of handling these bonds. The greater majority of contractors wish to establish their bonding connections with their own company, and furnish the bonds, adding the cost to their bid price.

Under the other method the owner uses his own insurance counsel and insurance connections to obtain the required bonds from the contractors that he intends to invite to bid. Although this method is used less, it seems equally satisfactory. Premium for such bonds would be paid by the owner, and it should be understood that they are not included in the contractor's bid price. The advantage of the owner using his own surety company lies in getting a direct picture from a known and trusted source. Often the surety offered by the contractor is entirely unknown to the owner, thus making necessary an investigation of the caliber of still another firm.

LIABILITY INSURANCE

Liability insurance is perhaps the most important phase of the insurance section because the possibilities of loss are greater and are more difficult to predict. Sufficient publicity has certainly been given to the changing attitude in regard to legal liability. Many institutions that formerly enjoyed "charitable immunity" are finding that this doctrine is rapidly becoming obsolete. It is now imperative that liability insurance cover all phases of any operation. Here again the services of a competent insurance counsel or agent are mandatory, even including consultation with the owner's counsel. It is a complicated situation at best; but if certain basic fundamentals are followed, most situations can be adequately handled.

The contractor should be required to maintain complete bodily injury and property damage liability insurance for both the general operations and automobile exposures on a standard form of comprehensive policy or policies. The insurance should cover all sections, including such hazards as products, completed operations,

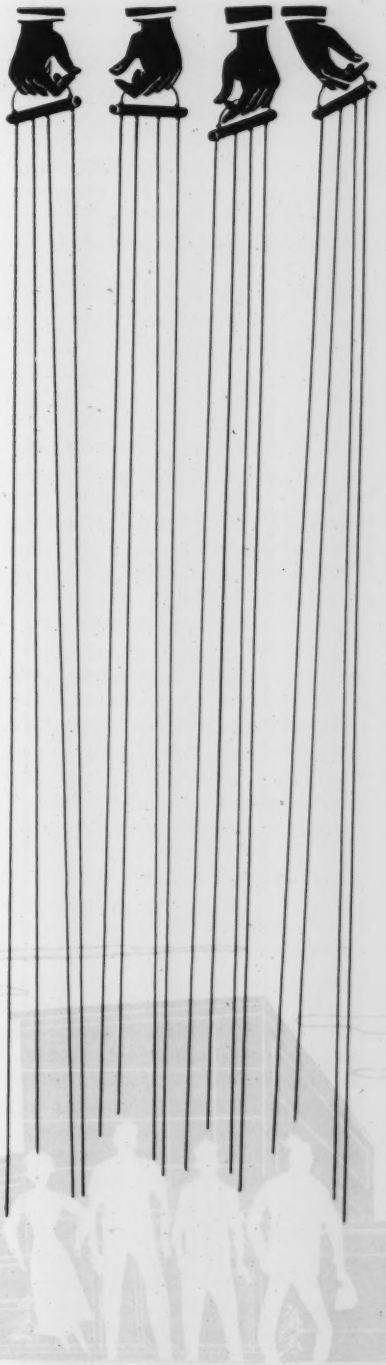
(Continued on page 100)

*Statistics included in an address by Alexander Kerner, vice president of the bond department of the Federal Insurance Company, at a meeting of the National Insurance Buyers' Association in New York.

Who controls your hospital?

by GUSTAV A. KILLENBERG

Management, which includes trustees, administrator, doctors, department heads, and employees, is the prime force that ultimately influences hospital costs. Accounting controls are not the exclusive province of the comptroller. Even the finest controls cannot reduce costs unless management understands and uses them in its day-to-day operations.



IN 1947, THE per patient cost in nonprofit general hospitals approximated $10 for each patient day. By 1954, the cost had risen to some $22. Newspapers, magazines and other publications continue to be critical of the high cost of hospital care. Conversely, the American Hospital Association, and many thoughtful writers, have been engaged in an educational program to enable the public to understand the reasons for such high costs.

Truly, the public is aware that hospital costs have increased. It is asking such pointed questions as: "Who is responsible for the efficient operation of these vital institutions? What are these people doing about it? Who controls these hospitals? Who makes sure that the best service is being rendered in the most efficient manner and at the lowest possible cost?"

It is entirely reasonable that the public ask these questions. In the final analysis, it's the public that pays the entire cost, whether through insurance contributions, direct payment for services rendered, public subsidies, community funds or direct gifts.

In some areas of the country, Blue Cross and other third party payers have demonstrated considerable resistance to further increases in the reimbursement they are making to hospitals for the care of their subscribers. Some of this may be attributed to the normal business habit of obtaining the maximum for a minimum payment. More likely, however, these agencies are reflecting subscriber resistance to a further increase in the contributions. Blue Cross, for example, is really a hospital agency born during depression years for the purpose of assisting hospitals in reducing their free-care load. As such, it can very well be considered to be a specialized department of each hospital. Its present warnings could be construed to be advice from the hospital's own expert that further increases in costs are not going to be readily accepted by the public. If this thought has any merit, then the hospitals must be absolutely certain that they are controlling their costs and are justified in their requests for larger payments from the public.

Control is often thought of in the narrow sense of an accounting function within a hospital. Directly within such a sense, Robert H. Reeves, accounting consultant to the Rochester (N.Y.) Regional Hospital Council, made this statement:

"My experience during the past seven years convinced me that very few hospitals have an adequate system of internal control. Reasons for this unfortunate condition may vary but there is always one common denominator—management—(which includes or consists primarily of the chief accounting officer) which is not meeting its responsibility."

ADEQUATE CONTROL SYSTEM

In many hospitals, the accounting controls would suffer in comparison with those found in the business world. However, even the finest accounting controls cannot effect a reduction of costs unless they become a living, vital part of management. Management's deci-

Gustav A. Killenberg, C. P. A., is a partner in the firm of Harris, Kerr, Forster & Co., accountants and auditors consultants. This article was adapted from an address made by Mr. Killenberg before the New Hampshire-Vermont Chapter of the American Association of Hospital Accountants.

sions and judgment are chief ingredients ultimately reflected in hospital costs. Management controls the hospital. Control is not the sole province of the comptroller or chief accounting officer. Accounting only provides the background of information to enable the true control to function from day to day.

But who is management? Management consists of a team composed of the trustees, administrator, staff doctors, comptroller, department heads and employees. Costs, and their control, are definitely within the sphere of influence of each of the members of this team. As the focal point in this whole scheme, the administrator receives principal credit, and all of the criticism, for the control of the operation.

ROLE OF THE TRUSTEES

The trustees, whose prime function is at policy level, can, through their decisions, greatly affect the ultimate cost of operation. Some of these decisions may have been made before the hospital has opened some 20 years ago and they still affect the day-to-day operations at the present time. Lack of careful planning from an operational viewpoint when the hospital was built is one such example. While it is true that no one has ever designed and built a building which was perfect in every respect, all too often the desire for esthetic beauty has dimmed the operating requirements. The completed building may be burdened with a mortgage (excessive operating costs) that can never be paid off, because plans were not completely and carefully reviewed from every operating standpoint. There are cases where the board of trustees has dictated policies as to type of service to be rendered in the dietary department or nursing service, for instance, without consultation or information as to the increase of costs involved.

All too often, trustees are appointed or elected because of their fund raising ability or connections, and consider the job an honorary one requiring their presence at a meeting for one hour, once a month.

A conscientious trustee should require explanations of the administrator and comptroller until he is fully familiar with the trend of the hospital's operation. He should receive financial information in a concise and complete manner. As a president and treasurer report to their board of directors, so must the administrator and comptroller take the board into their complete confidence.

INFLUENCE OF MEDICAL STAFF

The medical staff of the hospital cannot ignore its responsibility for cost control. While its primary job is to control the quality of medical practice in the hospital, it can exert a strong influence on the ultimate cost of services rendered. Wasteful practices can creep in when the staff is not fully informed; practices such as using antibiotics almost indiscriminately on the theory that they don't hurt the patient, or admitting a patient with a therapeutic explanation covering diagnostic work so the patient's bill will be covered by Blue Cross. In most instances, this is done without realizing it is the hospital's cost that is being increased and the hospital does not always receive complete reimbursement from the third party payer. The staff doctor's preference for certain specific surgical and medical supplies is understandable, but this, too, can get out of hand to the extent where, in the ultimate, different brand labels have to be carried for almost every doctor on the staff. These and other similar practices, which tend to increase costs, often arise from a lack of information by the staff doctors. This can be avoided if the administrator and/or comptroller are invited to attend at least the nontechnical aspects of staff meetings and there be given the privilege of setting forth their side of the story. The staff should be kept informed of the financial problems of the hospital and particularly of the financial effect of some of their decisions. Given an opportunity to know the financial effects of their decisions, their judgment will be fortified by further information to the ultimate benefit of the hospital. They cannot exercise their portion of the control unless they are kept informed.

On the comptroller or chief accounting officer rests the responsibility for establishing internal accounting controls. He must see that they continue to function, preparing necessary reports to keep all of the team informed as to the financial experience of the past and the trend of the present and probable accomplishments of the future. In a large hospital, internal controls can be complete and complex, but in a smaller hospital, one can readily fall into the error of establishing accounting controls which cost far more than their worth. Perpetual inventories and extensive accounting operation of budgets are fine approaches to the problems, but they are not the only ones. They merely report deviations from expected expenses without necessarily giving any reasons. It is very much like a set of books that is in balance, but nevertheless contains many errors. The accountant must, therefore, provide sufficient control to maintain a current and comprehensive view of the financial operation. Yet, by the exercise of judgment, he must take care not to overburden the operation to the point where the ultimate goal is lost by the very expense of his attempt to attain it.

The chief function of the comptroller, as part of the control team, is to present information to all parts of the team so that it can be readily assimilated. The information should provide the important factors without obscuring them in a mass of detail. Since each member of the team has different needs, different types of reports may be needed for the trustee, administrator, staff doctors and the department heads. The trustee needs a condensed, concise report, dealing with the operating figures, the key statistics and balance sheet items. The medical staff, for the purpose of its meetings, should be provided with a similar report. The administrator, as well as any operating committee of the board of trustees, should have a complete detailed report containing as much information as the books of account and available statistics afford. The department heads are, of course, interested primarily in the operation of their particular departments. Reports to them should contain only such information.

In each instance, the report, to really mean anything, should be

compared with either the budget or previous experience. In some instances, a comparison with both is indicated.

COST ANALYSIS

The comptroller's obligation does not end here, however. If he is truly performing his function, the comptroller should be constantly alert for operating problems and make special financial analyses of these problems. It may be interesting to note that a number of hotels, and particularly those connected with the large and successful chains, have adopted the practice of employing a cost analyst, whose sole function is to analyze the operation of the various cost centers. The objective is to bring to management's attention trends that are increasing costs and the reasons for these trends. In this manner, these hotels have been able immediately to take steps to change uneconomic procedures. While there is a vast difference between the operation and the operating dynamics of a hotel and a hospital, such an analyst in any hospital of more than 100-beds would more than pay his salary. Persons with this training and mental approach are difficult to find and harder still to induce to accept positions in a hospital, where the outlook does not normally have the same breadth as it would in the commercial field. However, the comptroller is by training equipped to make such analyses and he must perform this function if a cost analyst is not available.

The comptroller or the accountant, however, must also be kept fully informed by the other members of the team. He can hardly expect to perform his duties efficiently, if he is kept in the dark as to the thinking and decisions of the rest of the team.

The influence of department heads on the ultimate cost of operation is also considerable. Within their own departments, each of them can appreciably increase or decrease the over-all per diem cost. In fact, the effect of their efforts, or rather lack of them, very often goes unnoticed for extended lengths of time. The housekeeper who does not carefully plan her staff's work schedule can often cost the hospital an additional employee or excess cost in the matter of supplies. The engineer or superintendent of maintenance who does not plan and execute a continuous preventive maintenance schedule burdens the hospital with expensive repairs that could have been avoided. The dietitian who becomes lax in competitive buying, who accepts commodities at weights other than those determined to be best suited for the hospital's needs, adds costs to the hospital's dietary expense. The director of nurses who is too busy to preplan the nursing coverage and maintain a well thought out ratio between graduates, aides and other assistants, who permits indiscriminate use of supplies and linens, adds her share to the increasing costs. Each department head, regardless of size or relative importance of his department, exercises a portion of control in a hospital.

REGULAR MEETINGS

Certainly they, too, should be kept informed. A regularly scheduled meeting of department heads, in which there is free discussion and interchange of ideas between departments, is one answer to the problem. Many administrators feel their busy schedule makes it virtually impossible to have these meetings. However, where such meetings have been worked out on a regular basis, they have been productive of much good thought, many new ideas and a spirit of team play that can only benefit the hospital.

We must also look for control to the employees themselves. In industry, training programs and indoctrination have become bywords. But, how many hospitals have taken the time and effort to formalize the training of their old or new employees, or in any way to standardize their work, or to any extent indoctrinate them into the thoughts and objectives of the hospital's management?

The receiving clerk who does not properly perform his function, the elevator operator who delays transportation from floor to floor, the fireman who neglects to adjust oil mixtures, the billing clerk who misses charges, the nurse who misuses linen, the storekeeper who improperly stores fresh produce—all contribute to avoidable costs. Over a period, the department heads through their supervision will correct these faults if they are found, but it would be far better to instill in these employees the knowledge and the desire which will induce them to do the job right in the first place. Training and indoctrination through periodic meetings is certainly part of the answer. The rest of the control team needs their cooperation too much to leave their performance to chance.

ADMINISTRATIVE CONTROL

Let us now consider just where the administrator fits into the picture. The board of trustees is generally made up of businessmen whose business judgment certainly must be acknowledged. The staff doctors are professionals in their own fields of medicine. The administrator, having served his apprenticeship and attained the stature of his present position, is the professional in hospital operation, who must be the guiding hand that assures a smoothly operating, efficient, cost-conscious organization. The trustees and staff doctors should look to him for guidance and advice as to the practicalities of changes or revisions in policies and procedures. The department heads, too, must look to him for guidance in their day-to-day operations. But at his right hand must be the comptroller to supply him with current and daily operating information, so that he can keep his finger on the pulse of his institution.

Each administrator should daily receive a report containing not only the statistics as to the number of patients cared for, admitted and discharged, but also the total charges of the previous day, the food cost per meal, the number of employees on the payroll, and the salary cost of that day. In addition, he should be supplied daily with pertinent statistics on receivables, cash balances. Without these, he is to some extent operating like a captain on a ship in foggy waters who receives a compass reading only at infrequent intervals. His comptroller, or navigator, must keep him currently informed.

Monthly, he should receive a detailed report on operations wherein major variations can be spotted

(Continued on page 102)

an analysis of a fringe benefit program

by GEORGE M. HARPER JR.

A hospital's fringe benefit program should be examined carefully in terms of expense and adequacy. One purpose of this study of a hospital's fringe benefit program was to determine if policies previously designed for a small staff were adaptable to a larger staff. Another aim of the study was to determine the adequacy or inadequacy of the hospital's fringe benefit program and to develop possible improvements.

GREENVILLE GENERAL Hospital is a 450-bed general hospital in Greenville, S. C., serving a city of approximately 70,000 inhabitants and a county population of approximately 190,000. In 1955 the hospital operated with an average of 562 full-time employees and 33 part-time employees.

The hospital completed an expansion program in 1953. During the same year a personnel department was established and a long-range program was initiated to improve the hospital's position as an employer in the community. Initial steps of the program were the conversion of the maintenance system to a full cash basis and the development of salary scales. Personnel policies were added to the hospital's policy and procedure manual after being reviewed and revised by department heads and approved by the administration.

George M. Harper Jr. is personnel director of Greenville (S. C.) General Hospital.

chart 1

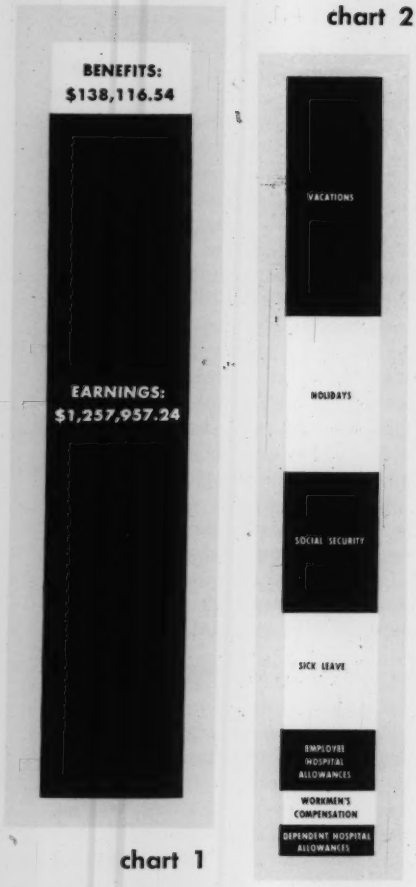


chart 2

COST OF BENEFITS

The administration became seriously concerned with the cost of fringe benefits in 1954. A review of available records disclosed that costs in one area had more than doubled in one year. The question facing administration was whether the hospital could offer to its enlarged staff benefits designed for a smaller staff and at the same time make a definite salary improvement.

In a series of conferences it was generally agreed that fringe benefits do assist in stabilizing a staff and that future goals of the hospital should include: (1) Assistance to the employee in current emergencies; (2) Assistance to the employee in preparation for retirement; (3) Provision for annual leave without loss in salary.

There were insufficient data available upon which to evaluate current costs and begin formulating a general long-range program. A study was initiated in 1954 to obtain this needed data, and was extended to analyze the costs of all fringe benefits in 1955.

The study was designed to (1) separate from payroll costs the expenditure for which no work time was received and by combining these hidden costs with additional employee expenses to determine total annual cost of fringe benefits; (2) determine the manner in which the benefits were utilized; and (3) determine the total time lost from work for which salary was continued.

Data collected were used to evaluate the costs of current benefits individually and collectively, to analyze areas of greatest utilization of protective benefits, and to determine if savings from policy adjustments would be sufficient to support salary scales, additional benefits or additional staff.

SUMMARY OF BENEFITS

The study covered the costs and, if applicable, utilization of the following benefits during 1955. These benefits form the basis of personnel policies at Greenville General Hospital.

1. Vacations—Employees earn one week's vacation upon completion of each six months of employment. After 10 years they earn one and one-half weeks per six months. Department heads and supervisory nursing personnel earn one and one half weeks for each six months of employment. After five years in the position they earn two weeks per six months. Vacations are granted in any season, and are not ordinarily cumulative beyond 12 months entitlement. Terminal vacation is payable in earned units of six months, provided due notice is received.

2. Holidays—The hospital recognizes six paid holidays annually: New Year's Day, "Spring Day" (may be taken anytime during the spring months), Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

3. Sick Leave—Positions are grouped into two categories for determining allowances. Each category contains about half the staff. Allowance is granted on the basis of work days—not calendar days. New employees in the first category earn one day per month for the first six months and thereafter are entitled to any unused portion of 12 days for the first year. The second and third year have a maximum of 12 days and subsequent years a maximum of 24 days. New employees in the second category earn two days per month for the first six months and thereafter are entitled to the unused portion of 24 days for the first year. In the second and subsequent years the maximum allowance is 24 days. The policy applies to bona fide illness only, and entitlement is not cumulative from one year to another. No payment is ever made in lieu of unused allowance.

4. Hospital Allowances—The hospital furnishes ward care at no cost to any full-time employee in need of hospitalization for a period not exceeding 45 days per year for each separate illness. Ward care is provided at a 50 per cent discount for the employee's immediate family and for maternity. A new employee must be employed by the hospital for 90 days before he or his immediate family is eligible for the benefit. Ten months' employment is required before an employee or dependent is eligible for the maternity allowance. The hospital does not buy prepaid health insurance. However, the allowance granted in cases of employee hospitalization is modeled after the South Carolina Blue Cross Individual Ward Plan.

5. Workmen's Compensation—In addition to annual premiums, the state industrial commission's payments are supplemented by the hospital so that the injured employee receives full salary during the disability.

6. Retirement—The hospital participates in Social Security as the only retirement program.

Time consumed in collecting the data was not as great as a first glance might indicate. All of the desired information was available. It had to be processed at some time in order to administer and control policy benefits for each individual. Employees absences were recorded on time sheets for payroll purposes. Other expenses were recorded and processed in the business or accounting office. The problem was not one of devising a means to establish the data but one of assembling that already available.

ASSEMBLING DATA

It was decided that the personnel department would be the logical department to assemble the data, since it maintained central employee records and posted paid absent days to individual employee records. Only one additional procedure was needed to consolidate and study information separated in individual records.

Two journal sheets with a total of 26 vertical columns were used for recording and analyzing absent days and costs. The sheets were labeled A and B and the first 12 columns of each were headed by a month of the year. The first section was used to post days of sick leave and compensation days and the second for posting vacation days and holidays. Employees were listed down the left margin of Section A by name and department. Using time sheets from each pay period, absent days paid each individual and the calculated costs were posted opposite his name in the appropriate section and monthly column.

Totals for a month were obtained by adding the days and costs posted for each of the four benefits. The sheets thus provided totals of days off and manner utilized for each department or for the entire staff. Individual records were reviewable at a glance and comments were noted in the 13th column of each section of the journal. The procedure of consolidating paid absent days occupied one person approximately two days per month.

The business office posted employees' and dependents' hospitalization allowances for accounting purposes. Each month the personnel office was furnished a summary report of days and amount of allowance granted each employee and each dependent.

A summary of data collected became a part of the monthly personnel report. A summary of the monthly reports at the end of the year, plus compensation premiums and Social Security payments obtained from accounting, gave the total fringe benefits costs for the year.

The study disclosed that the total cost of fringe benefits for an average full-time staff of 562 employees represented 9.9 per cent of the total annual labor expense (Chart 1).

table 1—fringe benefits utilization and costs

FRINGE BENEFIT	NUMBER OF INSTANCES	NUMBER OF DAYS GRANTED	TOTAL COST TO HOSPITAL
Total all benefits			$138,116.54
Total paid absences from work	5,268	11,909	94,137.95
Sick leave—total	1,013	2,848	21,655.75
3 days or less	804	1,136	8,705.08
4 days or over	209	1,712	12,950.67
Vacations	876	5,443	43,716.86
Workmen's Compensation (salary supplement)	6	245	694.96
Total other benefits			$43,978.59
Hospitalization allowances—total	214	1,493	15,144.52
Employees	145	1,004	11,944.62
Dependents	69	489	3,199.90
Workmen's Compensation premiums			2,976.12
Social Security			25,857.95

table 2—vacation days

	NO. TIMES GRANTED	DAYS	AMOUNT
January	10	42½	$ 343.40
February	12	55	444.40
March	21	101	820.12
April	48	338	2,844.86
May	65	416	3,341.66
June	98	725½	5,853.13
July	182	1,338½	10,999.68
August	206	1,330½	10,484.80
September	83	422½	2,572.22
October	55	279	2,323.17
November	42	189	1,522.41
December	54	205½	2,167.01
	876[1]	5,443½	$43,716.86

[1]876 represents the number of times that employees left for vacation. Because records were not kept on the number of employees having split vacations, the actual number of employees receiving a vacation is not estimated. The average number of days taken was 9.7 per employee.

table 3—utilization of days of sick leave, January through December 1955

	THREE DAYS OR LESS		OVER THREE DAYS		TOTALS	
	no. times granted	days	no. times granted	days	no. times granted	days
Jan.	66	99	26	180½	92	297½
Feb.	68	104½	21	134½	89	239
March	78	110½	21	218	99	328½
April	70	96	18	126	88	222
May	51	75	14	126½	65	201½
June	45	61½	13	134½	58	196
July	43	61	15	141	58	202
Aug.	65	92½	19	130	84	222½
Sept.	74	111	15	152½	89	263½
Oct.	96	131½	16	125	112	256½
Nov.	81	121	19	151	100	272
Dec.	67	72	12	93	79	165
	804	1,135½	209	1,712½	1,013	2,848

table 4—approximate cost of days of sick leave, January through December 1955

	ONE DAY	TWO DAYS	THREE DAYS	TOTAL COST 1, 2, & 3 DAYS	MORE THAN THREE DAYS*	GRAND TOTAL
January	$ 279.32	$ 337.92	$ 111.60	$ 728.84	$ 1,427.98	$ 2,156.82
February	343.08	201.47	242.28	786.83	1,025.30	1,812.13
March	359.98	304.36	216.56	916.90	1,913.00	2,829.90
April	370.16	285.92	133.82	789.90	934.44	1,724.34
May	223.40	162.52	174.74	560.66	845.96	1,406.62
June	258.04	113.28	77.16	448.48	1,122.24	1,570.72
July	203.77	177.28	106.32	487.37	1,038.65	1,526.02
August	308.38	227.24	163.80	699.42	872.82	1,572.24
September	331.67	219.80	284.40	835.87	1,049.40	1,885.27
October	402.56	391.96	185.88	980.40	958.96	1,939.36
November	357.35	365.84	224.27	947.46	1,103.34	2,050.80
December	278.12	109.02	135.81	522.95	658.58	1,181,53
	$3,751.83	$2,896.61	$2,056.64	$8,705.08	$12,950.67	$21,655.75

*If the duration of the illness exceeded three days the total payment was entered in this column.

Therefore, for each dollar earned, the hospital provided 9.9 cents.

During the year, time off with pay was granted in 5,268 instances totaling 11,909 working days — a complete year's work for 41 people. Time off with pay included vacations, holidays, sick leave, and a few instances in which salary was supplemented for compensation cases. A summary of instances, days and costs for all benefits is shown in Table 1, page 45.

Proportional costs of the various individual benefits are shown in Chart 2, page 44. Even though vacations were granted throughout the year, 44 per cent of the instances occurred July and August (Table 2).

SICK LEAVE RANKS FOURTH

Payments for days of sick leave ranked fourth in fringe benefits expense; 530 employees were granted time off with pay. Approximately 260 employees repeated illness once or more. Other sick leave data appear in Tables 3 and 4. There were 853 different individuals on the full-time payroll during the course of the year; 62 per cent received payment for time lost due to illness. There were 498 instances of illness not exceeding one day, and 39.8 per cent of the days were utilized by illness not exceeding three days.

Average number of days utilized per sick employee was 5.4. If maximum protection had been cut to 10 days, only 58 or 7 per cent of the employees would have been affected to various degrees. The days granted would have been reduced by 321 and costs reduced approximately $2,500. If no payment had been made for the first day the cost would have been reduced by $5,323.51. Eliminating the first three days would have reduced paid days by 1,762 and the cost by $13,420.12. The greatest number of days were utilized in March and the least number in December. Total days of sick leave for the last eight months of 1954 did not differ significantly from the total for the last eight months of 1955.

Hospital allowances ranked fifth in fringe benefit expense; 17.5 per cent of full-time employees were hospitalized (Table 5). Sixty-nine dependents were hospitalized for a total of 489 days of care. The average length of stay was 7.9 days

for employees and 7.4 days for dependents, as compared with 8.0 days for all patients. The average allowance was $82.38 per employee and $46.38 per dependent. There were 120 employee admissions that did not exceed 10 days. This portion of the admissions utilized 600 days and $7,126.71 in allowances. When comparing 1954 with 1955, there was no consistency in costs per month; however, there was no significant change in total costs for the two years.

IMPLICATIONS

The statistics for the year reveal a number of interesting but certainly not conclusive implications. The liberal aspects of the protective policies produced no alarming costs, since areas of greatest utilization were much lower than maximum protection. Results of the first year of the study imply that continuing analysis of utilization provides a key to reasonable control of the unpredictable protective benefit.

The vacation peak of July and August produced the only erratic fluctuation in work attendance. Potential control over this fluctuation lies in granting vacations the year round. There were few temporary replacements and moderate overtime payments during the year. Most time lost was covered by the staff on duty. Employee salaries were budgeted on the basis of a full year's work; therefore, it can be surmised that paid absences did not greatly affect the planned salary expense for the year. What we have learned in one year also indicates that we may need to take a closer look at our staffing plans and work situations to determine if absenteeism lowers the quality of service in some areas.

The purpose of studying fringe benefits was to determine if policies previously designed for a small staff were adaptable to a larger staff, from the standpoint of costs. There was no intent to alter existing benefits, which are considered essential to a good work situation. One aim of the study is to justify the current program or begin the development of a better one. One year's statistics are not conclusive. Conclusions can be drawn only after a number of years' experience. ■

table 5—analysis of number of days and costs of hospitalization allowances

DAYS OF UTILIZATION	NUMBER OF EMPLOYEES	TOTAL DAYS	ALLOWANCES
1	6	6	$ 199.29
2	11	22	319.65
3	25	75	896.55
4	16	64	602.84
5	13	65	664.14
6	16	96	993.21
7	9	63	790.87
8	12	96	1,271.18
9	7	63	782.12
10	5	50	606.86
11	7	77	934.33
12	3	36	415.46
13	1	13	186.30
14	2	28	298.36
15	4	60	670.29
17	2	34	429.15
18	2	36	544.80
26	2	52	397.71
33	1	33	630.30
35	1	35	311.21
	145	1,004	$11,944.62

table 6—proportional cost of gross labor expense and average cost per full-time employee

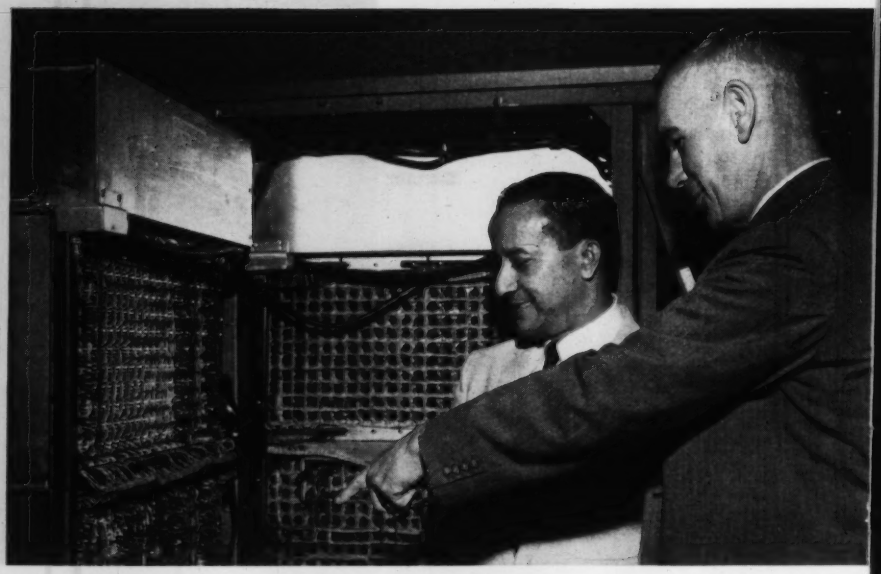
BENEFITS	EXPENDITURES	PERCENTAGE OF GROSS LABOR EXPENSE	AVERAGE COST PER EMPLOYEE	
			ANNUAL	MONTHLY
Vacations	$ 43,716.86	3.1	$ 77.79	$ 6.48
Holidays	28,070.38	2.0	49.95	4.16
Social Security	25,857.95	1.9	46.01	3.83
Sick Leave	21,655.75	1.5	38.53	3.21
Hospitalization Discount	15,144.52	1.1	26.95	2.25
Workmen's Compensation	3,671.08	.3	6.53	.54
	$138,116.54	9.9	$245.76	$20.47

table 7—days utilized and average absenteeism

BENEFITS	DAYS UTILIZED	AVERAGE NUMBER EMPLOYEES ABSENT PER WORKING DAY	PERCENTAGE OF FULL-TIME STAFF ABSENT PER WORKING DAY
Vacations	5,443	19.0	3.4
Holidays	3,373	11.8	2.1
Illness	2,848	10.0	1.8
Workmen's Compensation	245	.8	.1
	11,909	41.6	7.4

(LEFT) Storage section of the electronic data processing machine of Philadelphia Blue Cross which houses the unit's "brain". (BELOW) E. A. van Steenwyk, right, executive vice president, Philadelphia Blue Cross, shows Surgeon Lt. Commander S. S. Ahmad of the Pakistan Navy the open storage unit of the electronic machine with its banks of vacuum tubes and relays.

electronic system aids Blue Cross operation



by VERNON EDWARDS and BRUCE TAYLOR

Electronic data processing equipment is getting credit for speeding up payment and approval of Blue Cross claims in the Philadelphia area. The equipment processes Blue Cross data in the morning and Blue Shield data in the afternoon, and eliminates most of the manual effort required in analysis of hospital admission requests.

AUTOMATION HAS become standard procedure where growth has pressed beyond the practicality of manual labor. Such pressure is becoming evident in hospitals.

The special skills of comptrollers, admitting officers, accountants, statisticians, medical librarians and others who serve the patient in admitting and accountant capacities must necessarily be of high order. Necessary also, in order for them to keep abreast of rapidly expanding medical services and utilization, is efficient equipment with which to work.

Blue Cross has considered this need and is making use of a new branch of science—electronics—to bring automation directly to hospitals. The new science will help hospital business offices keep pace with pressing demand.

The electronic data processing machine installed by Philadelphia Blue Cross in January, 1956, employs the latest principles of electronic automation. This machine is used for high-speed approval or rejection of hospital admissions plus auditing and payment of hospital claims, also for Blue Shield claims in the Philadelphia area. The Philadelphia plan is the first Blue Cross Plan, also the first organization of any kind in its area, to utilize such an electronic device.

MANY ADVANTAGES

A review of the first year's experience shows that the machine has never made an error and has coded up to 3,800 cases a day (it has not yet been worked to its capacity thus providing a cost-free margin for growth). A clerk can manually code only about 100 cases a day.

These are the advantages of the new machine to hospitals, subscribers and the Blue Cross operation: 1) It requires only one simplified hospital admission form. 2)

Vernon Edwards was formerly a member of the public relations staff of The Associated Hospital Service of Philadelphia. Bruce Taylor is assistant director of The Associated Hospital Service of Philadelphia.

It eliminates most of the manual effort required in analysis of hospital admission requests. 3) It helps speed approval or rejection of admissions, and approval of hospital bills. Hospitals receive replies on all Blue Cross admission notices within 24 hours. Current tests indicate this can be reduced to two or three hours for many hospitals in the near future. 4) It makes possible quick reference to all necessary information for answers to telephone or other inquiries. 5) It creates a by-product of punched card records for later machine preparation of accounting and statistical reports.

A number of other Blue Cross Plans throughout the country are presently studying electronic data processing methods and considering the model and type of machine most suitable to their needs.

Recently, 90 representatives from Blue Cross Plans met in Philadelphia to examine the electronic equipment and to study results.

The transition in Philadelphia from manual processing to an electronic operation took time.

PLANNING STAGE

Basic preparation began in 1950 with publication of the Plan's *Business System for Modern Hospitals,* a mechanized simplified admitting and accounting procedure, since adopted by most of the hospitals in the area. Philadelphia Blue Cross shared in the cost of the accounting machines used by hospitals to make these improvements possible.

About three years ago studies began on still faster methods of notifying hospitals on approval or rejection of claims.

Active exploration began when a group of Blue Cross department heads went to St. Paul to study the status file system of the Minnesota Blue Cross Plan. The status file is composed of punched cards containing the history of each subscriber's account and information relating to the approval and eligibility of claims. A status file is essential to certain types of high speed data processing equipment. The status file also is of great value in a manually operated system for it keeps the latest subscriber information readily available. Among Philadelphia's 2,200,000 Blue Cross subscribers, there are 50,000 changes a month reflecting such factors as new jobs, marriages, births and deaths. The average is one change for every 44 subscribers.

After deciding to create a status file, the next question was: "Which type of machine can best utilize the file?" Many factors had to be considered: economy, preparation (including personnel training) required, and most important — the equipment which would best help meet Blue Cross' special requirements in services, doctors and subscribers. It was essential to design the status file so it could revert to manual operation in case of an unpredictable emergency.

TRANSITION PROBLEMS

Several major business machine manufacturers produce various types of electronic machines, each with its own characteristics and advantages, all of which were studied. The Philadelphia Plan chose the "650," made by International Business Machine Corp., as the one best suited to its needs.

This was only the beginning. Personnel had to be trained to use the machine. Eight employees attended classes at the manufacturer's Philadelphia offices and after intensive schooling, planned procedures to set up the status file. New cards had to be punched for each of Philadelphia's more than two million subscribers. This phase took three months to complete. A team of 60 men worked a 24-hour schedule for a total of 7,500 man hours.

The change to electronic processing was made on Jan. 3, 1956, and while the Plan was prepared to revert to manual operation if necessary, the program has proceeded smoothly. The ambidextrous machine processes Blue Cross data in the morning and Blue Shield data in the afternoon.

DIVERSIFIED OPERATIONS

For both Blue Cross and Blue Shield questions which can be answered yes or no, the machine will search out information from comparative tables and perform routines giving the correct answer.

When a hospital admission is analyzed, the computer decides whether the case is approved, rejected or requires manual handling because of discrepancies or lack of information. The complete operation takes nine seconds per claim.

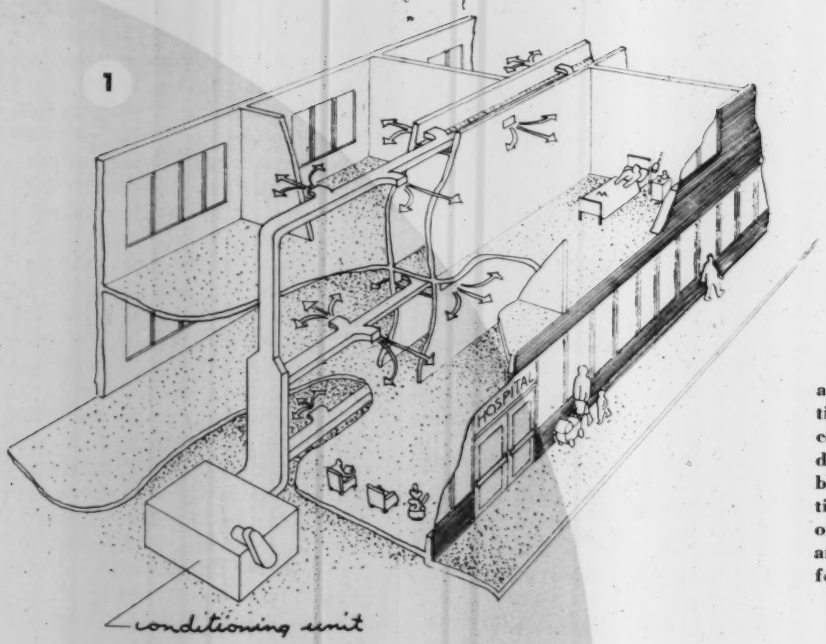
During the process, the machine polices itself. Internal checking circuits and devices keep data within the machine under constant electronic scrutiny. The machine tosses out a misfiled card for personal inspection, preventing the possibility of a "lost" subscriber card. Finally, it produces a card which shows the benefits available to the patient. If the coverage request is approved, a copy of the approval card is sent to the hospital. If rejected, the hospital and subscriber both are notified.

The computer has provided the basic "yes" or "no" decision more promptly and more accurately. In addition, it has reduced clerical work in the hospital for "accepted" cases by providing a card containing relevant information. Previously, these were typed on an individual basis by the hospital consultant.

Prior to actual installation of the machine, its merits were explained by E. A. van Steenwyk, executive vice president of the Philadelphia Plan, at two meetings attended by some 400 hospital administrators and their administrative staffs.

"We are confident," he told them, "that the use of electronics in data processing will result in better service to hospitals, better service to doctors and subscribers, and economy to the Plan. The new method strengthens the partnership between Blue Cross and hospitals and brings them even closer in their association. We believe that our experience has proved those predictions true."

To the 500 Blue Cross employees, Mr. van Steenwyk gave this assurance: "The mechanical marvels of the future will free many of us from routine work that machines can do as well, or better, than we now do. Their use will make it possible for others to be engaged in work which involves the full use of our experience and judgment, the unique and vital human qualities that machines will never be able to copy. You can't lose by making machines do work which will free you for other more rewarding activity." ■



Part 1 of this two-part article, which appeared January 1, discussed practical considerations in installing an air conditioning system, factors affecting design, measures for controlling airborne infection, and proper installation of filters. Part 2 examines various types of air conditioning systems and analyzes the specific needs of different areas within the hospital.

air conditioning the hospital—2

by RICHARD P. GAULIN

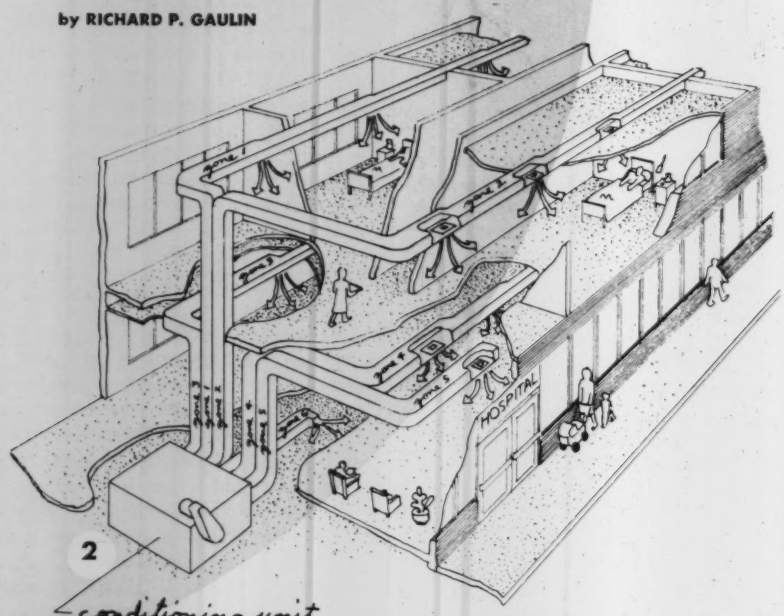


FIG. 1 (TOP) A central air conditioning system.
FIG. 2 (BOTTOM) Central air conditioning system with several zones for better control.

OUTDOOR AIR supply to hospitals may be relatively free of pathogenic contamination but may become more contaminated after entering the hospital. It is therefore desirable that the system be designed to limit the circulation of air from area to area and from patient room to patient room insofar as is practical.

5. Air Conditioning Systems

The design of the hospital air conditioning system will vary according to the size, type and layout of the structure, space allotments, orientation, climatic con-

Richard P. Gaulin is a mechanical engineer with the Division of Hospital and Medical Facilities, Public Health Service, United States Department of Health, Education and Welfare. This article was prepared under the direction of John W. Cronin, M.D., former chief, Division of Hospital and Medical Facilities, PHS. Dr. Cronin is now chief of the Bureau of Medical Services, PHS.

Author's note: This study was made possible through the interest and assistance of many who have contributed unsparingly of their time and efforts. Appreciation is expressed to all those in the fields of medicine, hospital administration, engineering and architecture, and to the staff members of the Division of Hospital and Medical Facilities, PHS, whose assistance has been very helpful.

ditions and many other factors. It is therefore impossible to prescribe a particular system which would be suitable for all hospitals.

LIMITED SYSTEMS

Many hospitals, due to climatic conditions, will require the cooling cycle for selected areas only, such as operating and delivery rooms, recovery rooms, special treatment rooms, nurseries, and obstetrical nursing areas. Such requirements will probably be best served by factory assembled units located outside of the area, utilizing conventional duct systems for air transmission.

TOTAL SYSTEMS

The designer planning an overall air conditioning system for the hospital has a wide variety of designs to consider. These include low- and high-pressure central systems adaptable to many modifications, as well as many types of individual room unit systems.

High-pressure systems, which are coming into more general use, have certain advantages over a conventional low-pressure system in that they require smaller duct systems and less elaborate central circuiting. The smaller ducts may reduce building cubage and minimize interference with the many concealed utility lines during construction. They lend themselves to a great variety of control arrangements. These advantages may in some cases be offset by the more expensive auxiliaries required. A combination high and low system may offer the greatest advantage in some instances.

Among the many variations of the high and low pressure systems are the following:

Central Fan and Duct System. This type of system serves the entire hospital. It concentrates all equipment, fans, coils, sprays, and filters in one location. Although it is adaptable to the small hospital, it does not provide the flexibility or control generally necessary to serve the many areas of a large hospital. This type system may be designed for either high or low pressure service.

Individual Factory Assembled Units. These are units of large capacity and a system designed for their use may require one or a number of units. Each unit consists of a fan, coil, and filter. The coils are served by remotely located refrigeration and heating equipment. These units may be located on each floor or one unit may serve several floors. This type of system may be either high or low pressure and may be further modified by:

1. Zoning to provide better control of varying load conditions.
2. Installation of reheat coils in zone ducts for better temperature regulation of zones.
3. Installation of reheat coils in the various individual room branch ducts for room temperature control.
4. A double duct system, one duct carrying cooled air and the other warmed air. The air is mixed at the individual room outlet for precise temperature regulation regardless of variations or changes in thermal loads in any part of the building.

With systems of this type, air distribution in the conditioned areas is generally by means of diffusers mounted on a window sill, wall, or ceiling. Window sill or ceiling diffusers may be of the conventional air delivery type or the aspirating type.

High Pressure Induction Type Convector System. This system, sometimes referred to as a perimeter system, consists of individual units in each room. The units contain a coil which is served by remotely located central refrigeration and heating systems. Primary air—usually fresh air—is conditioned at a central point or at individual floor units to compensate for latent heat gain in summer and latent heat loss in winter. This primary air is delivered to the room unit at high velocity and in passing through the unit induces a flow of room air over the unit coil, compensating for sensible heat gain or loss within the area according to the season. The induction ratio is usually about four to one.

Since the primary air travels at high velocity through the duct system and because the quantity per unit is comparatively small, the air is transported in small ducts which may be installed in pipe chases or be furred in at columns. Temperatures are controlled by throttling the water supply to the coils. Where the structure has interior areas removed somewhat from the perimeter which have different or varying load characteristics, a separate system or zone may be required to properly condition it. The individual unit coils will require seasonal cleaning.

Low Pressure Induction Type Convector System. This system is similar to the high pressure type but varies in that the individual room unit performs only a heating and reheating function. All primary air is cooled and dehumidified through a central system or individual floor systems and carried out by duct to the individual unit. Room temperatures are usually controlled by throttling the air supply through the unit. The heating coils may be sized to provide, by thermal cir-

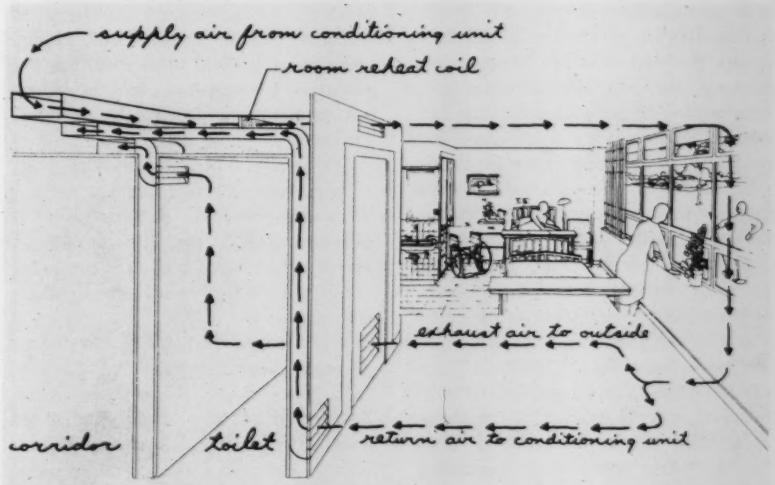


FIG. 3 How air is distributed within the room with a central system.

culation, minimum temperatures when the primary air supply is not operating. In areas requiring a definite ventilation rate a by-pass may be necessary to provide primary air volume.

Individual Room Units. These units are located on the outside walls, usually under windows, with a small opening through the wall to provide outside air. Each unit contains a fan, coil, filter, and motor. Chilled or heated water from a remote source is circulated through the coil in the unit for cooling or heating. These units have the advantage of not requiring a duct system but the disadvantages of providing no positive ventilation and affording poor control between seasons. Consideration should be given to the possible volume of maintenance required to service the many individual pieces of equipment.

Window Cooling Units. These units are not recommended for new buildings because of noise, drafts, poor temperature regulation, and maintenance and service problems resulting from the many individual pieces of equipment. Such units have been used to some extent in existing buildings.

The above systems are to be considered as basic and by no means include all systems or variation of systems which may be adapted to hospital use. Of these systems, those which operate on the principle of induction or aspiration and which provide approximately 20 per cent ventilation air with 80 per cent recirculation of room air lend themselves nicely to minimizing the recirculation of air between patient rooms. With such systems, the corridor serving patient rooms is pressurized with the small amount of air necessary for corridor ventilation. Corridor air is exhausted through all rooms opening on to the corridor. Patient room air, in an amount equivalent to primary induction air plus some corridor ventilation air, is exhausted through the patient room toilet or a similar exhaust system.

Often financial, structural, or other considerations will dictate the use of a design which recirculates the air of a patient area through the central conditioning system and redistributes it to patient rooms. Individual factory-assembled conditioning units with efficient filters in the recirculating system are recommended to confine this recirculation to a limited area, such as a nursing unit or floor. Such a system should reduce the hazards of cross-infection to a minimum in general medical and surgical nursing units.

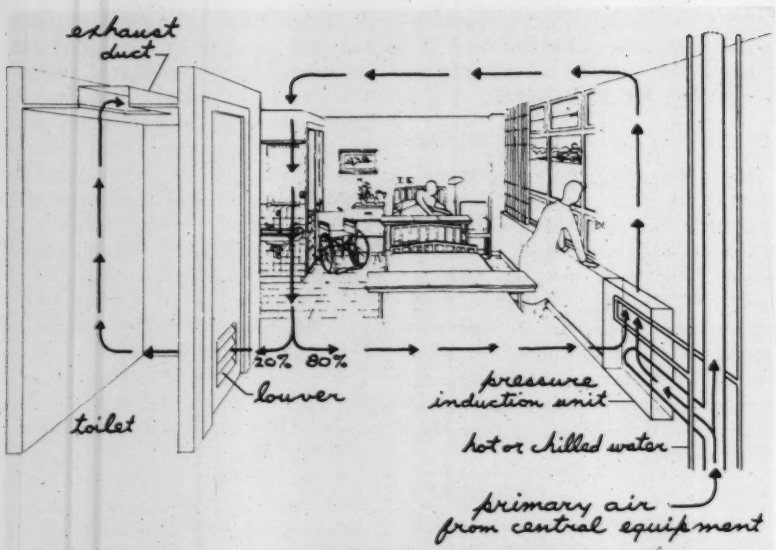


FIG. 4 An induction type air conditioning unit, with primary air and heated and chilled water lines.

The corridors of patient areas should not be used as exhaust air plenums. Such circulation is contrary to most fire safety codes and is not considered desirable for ambulatory patients or personnel who will traverse the corridors.

6. Design Criteria

It is not the intent of these criteria to cover engineering fundamentals or problems common to building construction, but rather to present special phases which are peculiar to hospitals and of interest to hospital architects and engineers.

It should be noted that air change rates as specified for specific areas refer to outside air requirements for ventilation and in no way reflect the air turnover required for the conditioning process.

For design purposes, the acute general hospital may be divided into its principal service areas. These will vary somewhat from each other in the design treatment which their function will require. These areas are (1) administration department, (2) diagnostic and treatment facilities, (3) nursery, (4) nursing department, (5) surgical department, (6) obstetrical department, (7) emergency department, and (8) service department.

ADMINISTRATION DEPARTMENT

This department, due to its function, will require no special ventilation treatment. General recirculation of air within this area, excepting toilets, would be indicated.

DIAGNOSTIC TREATMENT FACILITIES

Laboratory. While odor control in all of the laboratories should not be overlooked, only the bacteriology section and certain areas of pathology will require special attention relative to ventilation. Up to 75 per cent of general laboratory air may be recirculated if properly filtered, except that all air of virus or infectious disease laboratories should be exhausted to the outside.

Chemical fume hoods, with integral ventilation systems designed to void the hood and protect the personnel, will be installed in the laboratory area. Consideration should be given to hood exhaust capacities in computing general air supply and exhaust to the area. Hoods should be connected by noncorrosive vent lines through the roof and acid-resisting fans should be used. It is preferable to place the hood exhaust fan on the roof to prevent the possibility of acid

fumes being forced into the building.

Bacteriology—Because undue air movement is not desirable in this area, care should be exercised to limit air velocities to a minimum. A ventilation rate of 10 air changes per hour is recommended for the area; a negative air pressure should be maintained.

The sterile transfer room within or adjoining the bacteriology laboratory is a room where sterile media is distributed and where some types of specimens may be transferred to culture media. The air supplied to this room must be filtered at the point of entry to the room. Velocities at working level should not exceed 25 feet per minute. A glass fiber filter with 99 per cent efficiency, preceded by a dust stop, is recommended.

The media room, essentially a kitchen, should be ventilated to remove odors and steam.

The infectious disease (particularly tuberculosis) and virus laboratories of large institutions will require special treatment. To protect personnel, such laboratories will require ventilation at a rate of 10 air changes per hour with no recirculation. A negative pressure within the area should be established to prevent the spread of the organisms through the movement of air from room to room or to adjoining areas. Area supply and exhaust fans should be electrically interlocked so that the supply will shut off if the exhaust fails, but not the reverse. As protection for personnel, air should be exhausted at points as close to work areas as possible. The entire exhaust from the virus or infectious disease laboratories may be taken from slots or similar openings just above the work counters and from hoods.

Where the nature of the laboratory procedures with infectious microorganisms is such that a ventilated bacteriological hood or "safety cabinet" is provided, effective sterilization of the outboard exhaust is required. This may be accomplished by the use of electric or gas fired heaters designed to heat the air to 600°F. *(52)*. Some authorities recommend the installation of glass fiber filters in series with the electric or gas fired heater to insure against an interruption of work in the event the heater fails.

In many instances, only glass fiber filters are necessary. In this case, as a protection for maintenance personnel, an integral electric heater element may be provided as a source of 400°F. heat for dry sterilization of the filter media prior to changing filters.

Pathology—The areas of the pathology section which will require special attention are the autopsy room and, in larger hospitals, the animal quarters.

AUTOPSY ROOM—The autopsy room will require a minimum of 10 air changes per hour, with no recirculation, and a mechanical exhaust system which will discharge the air above the hospital roof. A negative air pressure is indicated for this room. Where the autopsy room will not be in constant use, it may be desirable to provide local control of the ventilation.

ANIMAL QUARTERS—The animal room will require 15 air changes per hour, with no recirculation, and a mechanical exhaust system which will discharge the contaminated air above the hospital roof.

Depending upon the type of work performed in the animal quarters, sterilization of outboard exhaust similar to that recommended for infectious disease laboratories may be required.

In larger hospitals in which exhaust air from the animal quarters may be carried in a duct system common to the laboratories, throwaway dust stop filters are installed at the animal room exhaust grilles to prevent animal hair from entering the main exhaust system.

Air diffusion to avoid drafts is of particular importance in the animal quarters. Temperatures of 75° F. to 80° F. with relative humidities of 40 to 50 per cent are usually required.

Radiology. In the radiology department, the fluoroscopic, radiographic, therapy, and dark rooms will require special attention. Among conditions which make positive ventilation mandatory in these areas are the odorous characteristics of certain clinical conditions treated, special construction designed to prevent ray leakage, and light-proof window shades which reduce any natural infiltration to the fluoroscopic area.

A positive ventilation rate of 3 air changes per hour with temperatures up to 80° F. and 40 to 50 per cent relative humidity should be provided for fluoroscopic, radiographic, and deep therapy rooms.

Depending upon the location of air supply and air exhaust louvers, lead lining may be required in supply and return ducts at the points of entry to the deep therapy treatment area to prevent ray leakage to other areas.

The darkroom will require eight air changes per hour. Exhaust from the darkroom and the film dryer in it are usually discharged directly to the outside. Because of the intermittent use of this room in small hospitals, local control of the exhaust may be desirable.

Physical Therapy. The cooling load of the electrotherapy section will be affected by the short-wave diathermy, infrared, and ultraviolet equipment used in this area.

The hydrotherapy section, with its various water treatment baths, will generally be maintained at

(Continued on page 68)

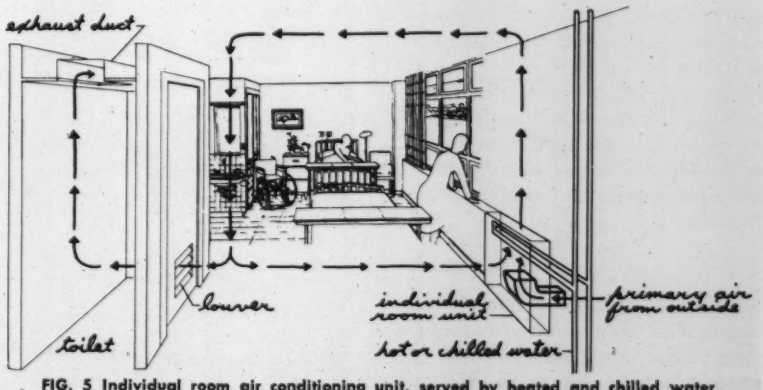


FIG. 5 Individual room air conditioning unit, served by heated and chilled water lines but receiving its ventilation air through an outside wall.

FIG. 1. (LEFT) General view of skin bank, which utilizes a space 12 ft. 2 in. by 9 ft. 10 in. Cold storage area at left is for storage at 4°C., —20°C., —40°C., and —79°C. At right is shelf storage area for lyophilized skin, supplies, and work table. Permanent record of the full course of each graft, experimental and clinical, is kept on file.

FIG. 2 (BELOW) Refrigerator for 4°C. skin storage, using various methods and storage areas for nutrients. Upper compartment is used for —20°C. storage. As much as 30,000 square inches of skin can be stored in such a unit.

skin bank stores postmortem homografts

by F. R. BRADLEY, M.D.; J. B. BROWN, M.D.; M. P. FRYER, M.D.; and T. J. ZAYDON, M.D.

When suitable recently deceased donors are available, a skin bank containing preserved postmortem homografts may be established at moderate cost. Such grafts will meet the demands for skin whenever there is need for homograft coverage of extensive open areas. The authors believe the postmortem homograft is the best source of skin to be used as a life-saving measure until permanent fresh autografts and survival can be established. The method of procuring and using postmortem homografts has become a recognized surgical procedure.

PATIENTS WITH full-thickness loss of skin from burns require skin grafting for healing, function, and rehabilitation. This group of patients presents a major problem at any time but particularly in time of local disaster and undoubtedly in case of an H-bomb attack.

F. R. Bradley M.D., is director of Barnes Hospital, St. Louis. J. B. Brown, M.D., is clinical professor of surgery at Washington University School of Medicine and chief of plastic surgery at Barnes Hospital. M. P. Fryer, M.D., is assistant professor of surgery at the medical school and assistant surgeon on Barnes Hospital staff. T. F. Zaydon, M.D., is fellow in plastic surgery.

Homografts are indicated for extensive deep burns, i.e., when too large an area of the body has been burned for survival of the patient, or for allowing the removal of graft, or for allowing the removal of graft from the patient himself. Hospitals that do much skin grafting should have a surgical staff trained to provide this surgical procedure, and should maintain their own skin banks for postmortem homografts. A skin bank can be established at reasonable cost and may occupy only a small space. In fact, the skin bank may become a part of a "tissue bank" for arteries, cartilage, bone, eyes, or vice versa, depending upon the hospital's needs and availability of material.

USE OF SKIN GRAFTS

The use of skin grafts for patients who have suffered extensive skin losses, particularly burns, has been practiced for years, but the grafts used were autografts; that is,

Now 2 Polysal®s

FOR I. V. THERAPY

The addition of a new Polysal now provides balanced electrolyte solutions for both replacement and maintenance.

For REPLACEMENT

Polysal

(REGULAR)

Balanced in terms of plasma electrolyte content, this high sodium solution is ideal in the treatment of dehydrated and depleted patients by replacing lost sodium and affecting *immediate* improvement in blood volume and circulatory status.

Write for literature

Simplify for Safety with

Polysal & Polysal-M

CUTTER LABORATORIES, Berkeley, California

*Talbot, N. B., Crawford, J. D., and Butler, A. M., "Homeostatic Limits to Safe Parenteral Therapy." New Engl. J. Med., 248, 1100 (1953).

For MAINTENANCE*

Polysal M

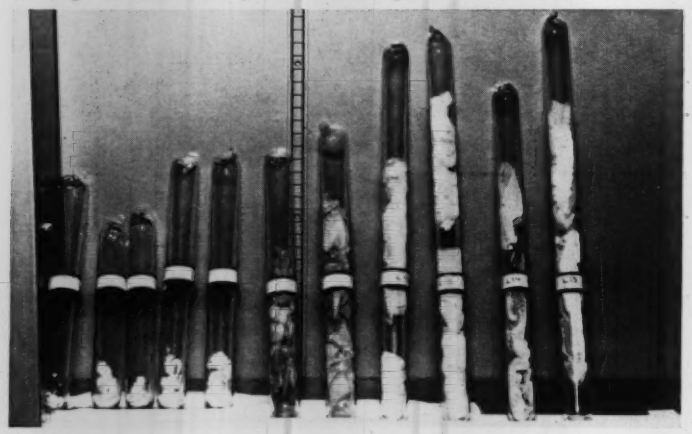
Balanced in terms of daily body needs for electrolytes, carbohydrates and water, this *Maintenance* solution is ideal for patients whose oral intake of food and water is restricted.

Polysal-M prevents the development of serious deficits which may occur in patients needing prolonged I.V. therapy by supplying the daily requirements in *safe amounts.*

"SAW-TOOTH" Effect Eliminated

This single solution delivers a smooth, uniform infusion, free from sharp peaks caused by daily infusion of several different-type solutions – thus preventing over-loading, water intoxication, edema formation.

FIG. 3 (ABOVE) Low temperature storage, with dry ice in insulated wooden chest is for skin storage at —40°C. Insulated chest, in center, contains dry ice-alcohol mush used for —79°C. storage. At right are blocks of dry ice.
FIG. 4 (BELOW) Shelf storage of lyophilized skin at room temperature in vacuum sealed glass tubes. Skin is spread out on firm gauze.



they were from patients' own bodies. There was still considerable loss of life and long convalescence because only a limited amount of skin could be obtained. Therefore, it was natural that the practice of using skin from another person (homografting) was developed. It was found to be a life-saving process to apply large sheets of splitskin homografts to patients who could not stand a long operation and who were going downhill from debilitation and pain.

Although skin from another person, unless it be from an identical twin, will not grow permanently on the patient, it has a life-saving quality because it survives from 20 to 40 days. During this time the patient is given relief from pain and dressings, his general condition improves, and there is a stimulus to his own ability to grow skin so that complete healing may occur even after the homografts are absorbed. In other words, the homografts become a "biological dressing" until permanent healing or autografting with the patient's own skin is possible.

At first, homografts were from live donors and carried with them obvious difficulties and disadvantages. One difficulty was the source of donors when large areas of the patient's body were to be covered. At times as many as 30 donors were required. The disadvantages to the donor were disfigurement, discomfort, loss of time, cost of hospitalization, anesthesia, treatment of the donor's wound, and occasional surface scarring.

It was a great advance when it was discovered that postmortem homografts may be obtained from patients soon after death and used in the same manner as fresh homografts. The method provides large amounts of skin from a single source without the disadvantages entailed in homografts from live donors. The advantages of obtaining large sheets of split-skin homografts from a single patient after death versus the disadvantages of obtaining an equal amount from live donors are obvious.*

Homografts of human skin from postmortem sources were first used on the plastic surgery service of Barnes Hospital in 1927, and to our knowledge this was the first time that a postmortem homograft was used for clinical purposes. This was later reported in the *Annals of Surgery* in October 1953. The possibility of having a stockpile of banked skin on hand to meet emergencies was so evident that extensive studies were made on the preservation and banking of skin from postmortem sources. As the method using postmortem homografts for seriously burned patients was demonstrated to be effective, Barnes Hospital was able to institute what we believe to be the first skin bank in a civilian hospital through the generosity of a grant from the Hartford Foundation made in October 1954.

*Recently on the front page of a large city newspaper a report was made of 100 persons offering skin for one burned child. This would mean 100 operations, anesthetics, dressings and loss of work, when the entire amount of skin needed could have been obtained from one postmortem source.

SOURCE OF POSTMORTEM GRAFTS

Postmortem donors furnish a vast source of homografts, provided that satisfactory donors are available. Signed permission for the removal of sheets of skin from unexposed areas on the donor's body is always secured even if an autopsy is to be done, but it is not necessary to have the full autopsy request. When relatives understand the life-saving possibilities of postmortem grafts, the method of removal, and that only the outer layers of skin are removed as a surgical procedure by trained personnel without disfigurement, permission is usually given without hesitation.

A member of the service requiring the skin presents the facts to the relatives of the deceased, and if necessary demonstrates the need by showing photographs of the burned patient, or by an actual visit to his bedside. The recipient patient or a relative must make a written request for the skin and he should understand its source.**

Removal of skin from donors is done in the operating room by an experienced surgical team or in the autopsy room with a mobile setup under the same sterile conditions. Thighs, abdomen, and lower chest, front and back, are shaved and prepared with soap and water and ether. Sterile drapes are applied and the grafts removed. Thin grafts will "take" better than thick ones; moreover, since they are not per-

**The reason that viable grafts may be obtained after death is that final death of skin does not occur at the time of general body death, but a good deal later. It is this differential in time between general and final death of the skin that makes these grafts available.

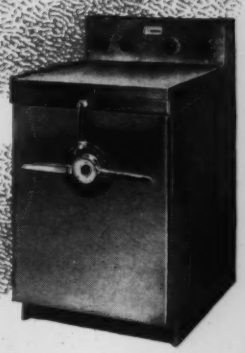
Now!

A BETTER TECHNIQUE FOR PATIENT UTENSILS . . .

THE *American* UTENSIL WASHER-SANITIZER

• The American Utensil Washer-Sanitizer provides efficient equipment to carry out an improved technique in preventing the transfer of communicable diseases among patients and hospital personnel. Convenient and automatic, it washes and sanitizes three full sets of patients' utensils in two loads . . . at a speed well within the normal discharge-and-admission rate. Simple and economical to install and operate, the Washer-Sanitizer saves personnel time, reduces Utility Room clutter and assures uniform cleaning and sanitizing at less cost.

For complete information on this new Utensil Technique, write for bulletin SC-321.



The American Utensil Washer-Sanitizer is available with stainless steel Utility Room clean-up counter or as the free-standing unit shown above.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

manent, thickness is not desirable. Sheets of thin grafts as wide as possible are cut with a free-hand knife with suction retractors; dermatome methods may be found to be too time-consuming. The grafts may be used immediately or prepared and stored in a variety of ways. Removal of postmortem grafts is done as soon after death as possible unless the body can be refrigerated. When the body has been kept refrigerated, viable grafts have been removed several days after death.[1]

REQUIREMENTS FOR SKIN BANK

The skin bank at Barnes Hospital was established and is being maintained by members of the plastic surgery service in space allotted in a convenient location (Fig. 1). The rooms contain a refrigerator (Fig. 2), freezers for low temperature storage (Fig. 3), a small file cabinet, a desk, a chair, lamp, waste receptacle, cabinet storage with sink, and an air conditioner. Skin stored for experimental and clinical use is shown and described in Figs. 2, 3, and 4. Animal experimentation, including that with skin from human sources, is carried out in an animal laboratory.

Fresh postmortem homografts and those stored at icebox temperatures "take" on a raw surface much like autografts do, but they survive only temporarily. Our surgeons found that homografts, frozen or desiccated by any combination of methods, last from 10 to 40 days. Fresh skin homografts remain viable for about 21 days when folded on saline antibiotic gauze sponges and stored at ordinary household refrigerator temperatures. There is some "take" of the refrigerator-stored homografts after 40 days, but it becomes poorer after three weeks. The skin is stored in an ordinary refrigerator at a temperature of from 3°C. to 5°C., and is ready for use upon removal from storage. If grafts are not used in 3 weeks, they are processed and stored at low temperatures or lyophilized (freeze-dried).

Low-temperature storage with glycerol is also used as a skin banking method. Skin is treated with 15 per cent glycerol in Earle's or Ringer's solutions with various combinations of nutrient media before storage at —10°C., —20°C., —40°C., and —79°C.

The following method is used: Split-skin grafts are placed for one to one and one-half hours in one of the glycerol solutions. After blotting the grafts with gauze, they are placed in a glass jar. Placing this jar in a second container provides an air jacket for the slow lowering of the temperature of the graft in a dry ice-alcohol mixture at —79°C. When this temperature has been reached, the inner jar is used for storage.[2] These grafts are used as needed by rapidly thawing them (immersing the jar in a 37°C. water bath or placing the grafts in sterile Ringer's solution kept at 37°C. until they are completely thawed). The glycerol is removed after thawing by placing the grafts in Ringer's or Earle's solution for one hour at room temperature before use.

Lyophilization or freeze-drying is a means of long-term storage of nonviable skin. Lyophilization occurs when skin is frozen; the ice is then evaporated, under high vacuum without melting, to a low temperature condensor. Freeze-dried skin can be stored at room temperature on a shelf, it is easily transported, it remains stable for prolonged periods of time, and it is ready for use within a short time. ■

[1] Brown, J. B., Fryer, M. P., and Zaydon, T. J., "Establishing a Skin Bank—Use and Various Methods of Preservation of Postmortem Homografts," *Plastic and Reconstructive Surgery*, Nov. 1955, Vol. 16, No. 5, 337-351.

[2] Ibid.

NOTES AND COMMENT

Group practice survey shows pattern for dividing income

In 1954 the Council on Medical Service of the American Medical Association and the American Association of Medical Clinics embarked on a joint survey of group practice. The purpose of this survey, as reported in the Aug. 4, 1956 Journal of the American Medical Association, "was to collect information that would be of value to physicians who desire to practice together in groups. The questions asked in the survey, therefore, were designed to provide answers that would shed light on what problems are faced by physicians in forming groups, how these problems are being met, and what constitutes a successful group."

The following comment on the findings of this survey is quoted from a preliminary report of the survey published in the Aug. 4, 1956 Journal of the AMA.

"It is obvious from the replies given that several different methods of division of income are in effect and that there is no single pattern that has yet emerged as being outstandingly 'best.' In general the method of equal division of income between physicians in a group appears to work fairly well if the senior partners who are receiving the equal division are of approximately the same age and capacities and lacking in personal jealousies. In larger groups, in which there is considerable variation in earning power by reason of age, specialty, amount of work done, and like factors, it often becomes difficult to continue such equal division.

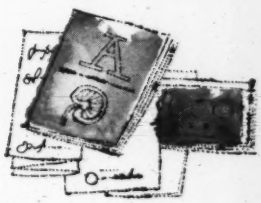
"Comparatively few of the groups base the income of the physicians on bookings alone. This illustrates the point that has been frequently raised about group practice, namely, that it should be a team activity and that physicians in groups are peculiarly dependent on each other for their professional earning capacity. Furthermore, as has been pointed out on numerous occasions, when the incomes of physicians in groups are based exclusively on bookings of the individual, in essence each physician is continuing to practice independently, though under one roof.

"The other sections of this report indicate that the methods of division of income employed are not necessarily completely satisfactory to the physicians involved. Consequently, many groups frequently reconsider the method that they use in such division; the general tendency in established groups seems to be for a departure both from completely equal sharing and from income based on bookings alone and toward the use of multiple criteria along the lines of the point system or by salary determined by an executive committee on the basis of similar criteria." ■

CIBA CAN HELP YOU...

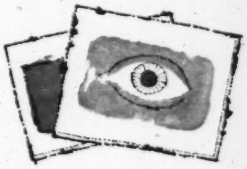
To obtain any of the numerous informational and teaching aids produced by CIBA, please write to the proper departments noted below.

LITERATURE



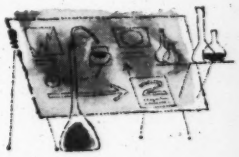
Booklets, brochures and reprints concerning CIBA products will be sent free of charge on request to the Medical Service Department, CIBA, Summit, N. J. In addition, two volumes of particular interest from THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS by Frank H. Netter, M.D. — Vol. 1, *Nervous System* (sold at cost, $6) and Vol. 2, *Reproductive System* (sold at cost, $13) — may be obtained by sending check or money order to Publication Dept., CIBA, Summit, N. J.

ANATOMICAL SLIDES



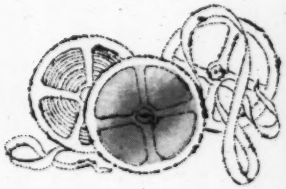
An extensive library of colored anatomical slides (art work by Frank H. Netter, M.D.) is available for loan or purchase. A complete list of the slides may be obtained by writing the Publication Dept., CIBA, Summit, N. J.

SCIENTIFIC DISPLAYS



The latest scientific information on products manufactured by CIBA is presented in exhibit form for the benefit of staff doctors — without interference with hospital routine. You may write to the Hospital Service Division, CIBA, Summit, N. J., requesting a display on a convenient date.

FILMS



A library of films in color with sound may be borrowed to be used as teaching aids for nurses, residents and internes, or as part of refresher courses and staff meetings. If you wish, projection equipment and a qualified operator will be provided without charge. A list of film titles is available from the Hospital Service Division, CIBA, Summit, N. J.

Booking Arrangements for Films: Please make requests at least 3 weeks prior to showing date to the nearest office of distributing agents —

IDEAL PICTURES CORPORATION:
East — 223-239 West 42nd Street, New York 36, New York Tel.: LAckawanna 4-0916
Central — 58 East South Water Street, Chicago 1, Illinois Tel.: FInancial 6-5245
South — 18 South Third Street, Memphis 3, Tennessee Tel.: 37-4313
West — 2161 Shattuck Avenue, Room 29, Berkeley 4, California Tel.: THornwall 3-6464
Hawaii — 1370 South Beretania Street, Honolulu, T. H. Tel.: 65336

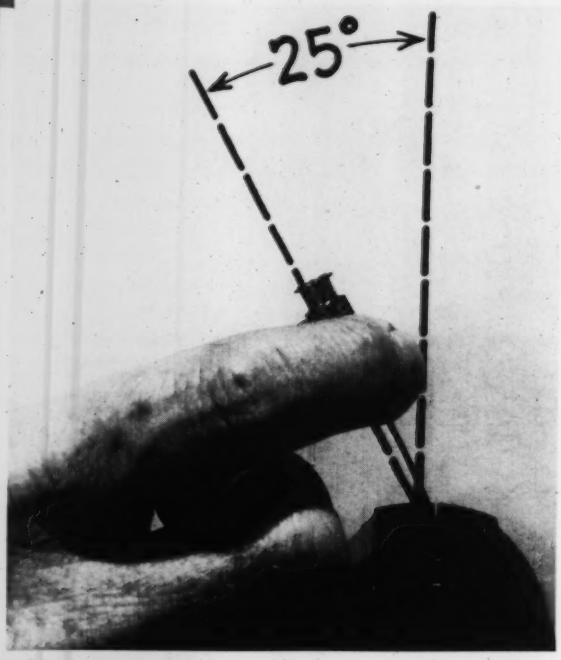
purchasing

NEEDLES, HYPODERMIC

FEDERAL CLASS NO. 6515

what to look for in purchasing hypodermic needles

by MARK BERKE



The following purchasing outline is the third of a series which will appear from time to time in this department. These outlines are intended to serve as "quick reference" guides for use in the writing of specifications on purchase orders.

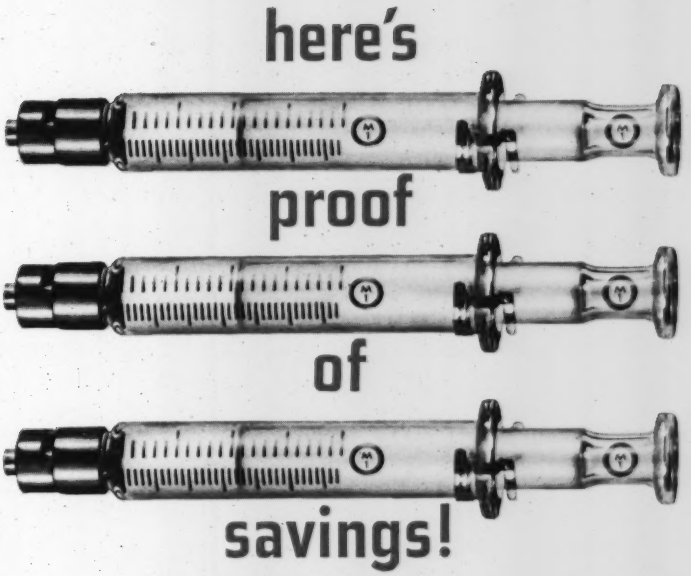
HYPODERMIC NEEDLES, unlike many products the buyer is called upon to evaluate and purchase for the hospital, vary little in uniform quality and service life when procured from one of the reputable suppliers in the United States.

The purchaser must be wary of an offer of an unknown or "off" brand at a "considerable saving." The "considerable saving" may eventually turn out to be a very costly transaction if, when put to use, the "off" brand needles leak, break easily, or corrode in a short time.

While most hospitals are not equipped with the technical facilities to test accurately the key points essential to a quality needle, the common faults of an inferior needle may be checked by several simple tests with equipment avail-

Mark Berke is director of Mount Zion Hospital, San Francisco.

HYPODERMIC needle being tested for breakage resistance (above) is bent 20 times both sides of vertical 20 to 25 degrees. To measure stiffness, an unknown brand needle may be checked against a brand known to be satisfactory simply by giving a hypo to an orange (left), which approximates the resistance of the human body. A test for corrosion resistance, boiling the needle in citric acid, appears on the cover of this issue.



B-D **MULTIFIT®** SYRINGES

In order to evaluate B-D MULTIFIT Syringes, five hospitals of varying size used them under normal conditions for periods ranging from 45 to 52 weeks. The impressive reduction in syringe consumption is shown below. It seems reasonable to expect that savings of at least 30 to 40 per cent may be anticipated by *any* institution using B-D MULTIFIT Syringes.

THE RESULTS:

REDUCTION IN 2 cc. SYRINGE CONSUMPTION IN 5 TEST HOSPITALS

Hospital (No. of Beds — Annual Admissions)	Duration of Test	Average Weekly Consumption of Ordinary Syringes (before test)	Average Weekly Consumption of MULTIFIT Syringes (during test)	Average Weekly Reduction in Syringe Consumption	Per Cent Reduction in Syringe Consumption
A — 345 beds, 11,729 admissions	52 weeks	19.23	5.03	14.2	73.8
B — 237 beds, 6,739 admissions	52 weeks	25.0	10.0	15.0	60.0
C — 250 beds, 10,387 admissions	52 weeks	26.57	17.557	9.013	33.9
D — 375 beds, 8,703 admissions	45 weeks	38.07	17.91	20.16	53.0
E — 520 beds, 9,086 admissions	45 weeks	38.92	22.177	16.743	43.0

How MULTIFIT provides these savings:

- **interchangeable parts** — every MULTIFIT plunger fits every MULTIFIT barrel.
- **reduced replacement costs** — you lose only the broken part rather than the entire syringe.
- **clear glass barrel** — virtually eliminates friction, erosion and breakage.
- **superior performance** — practically never any "back-flow" or "jamming."
- **ease and speed of assembly** — cuts handling time for personnel.

B-D **BECTON, DICKINSON AND COMPANY, RUTHERFORD, N. J.**

B-D AND MULTIFIT, T. M. REG. U. S. PAT. OFF

able in the ordinary hospital. The following tests can be made to check the key points listed in the purchasing guide.

1. LUER TAPER

The inside hub of the needle is tapered to accommodate the tip of the syringe. If the taper is true, and the syringe tip free from imperfections, the union of the two will be fluid tight to pressures commonly applied in general usage.

A check against leakage may be made by taking a syringe partially filled with water, sealing the needle point by slipping a solid rubber cord onto the point, and then depressing the plunger. If faulty, bubbles or drops of water will be observed.

2. SWAGING OF CANULA TO HUB

The attachment of the canula to the hub should be firm enough to withstand any ordinary pull exerted by the human hands.

Leakage at the swaging point may be observed during the test suggested for Luer taper above.

3. POINT

A. Burrs

B. Tip

C. Cutting Edges

The needle point must be sharp and smooth. It is the common practice of those trained in the use of needles to test for sharpness by drawing the point across a finger. A check for burrs may be made by drawing the needle point across a pad of common surgical gauze and noting whether it glides smoothly across the pad without catching or pulling.

4. CANULA

A. Resistance to Corrosion

The test cited in the Federal Specifications (E2a(1)GGN-196) can be carried out in the hospital. It provides that the canula should withstand immersion in 10 per cent citric acid at room temperature for 5 hours, boiling for 30 minutes, and remaining immersed for 48 hours in distilled water without showing appreciable corrosion after drying by evaporation. These tests should be made in a glass vessel.

B. Resistance to Breakage

The canula should have sufficient flexibility so that, with the hub in a fixed position, the canula may be bent 20 times both sides of vertical 20 to 25 degrees without breaking.

C. Resistance to Bending

In the absence of the technical equipment to measure stiffness as described in Par. E2b, Federal Specifications GGN-196, an unknown brand needle may be checked against a satisfactory known brand by simply giving a hypo to an orange picked up from the hospital kitchen and observing any excessive bending on the part of the unknown needle. Resistance of the orange to the hypodermic needle approximates the resistance of the human body.

When, in the opinion of the buyer, the situation warrants the testing of the needles offered, he should not rest secure in the knowledge that the salesman's samples passed the tests. The delivered shipment should also be checked by pulling an adequate number of samples and testing them before final acceptance of the order. The buyer may find considerable variance between the salesman's samples and the delivered merchandise. ■

Purchasing Guide

Item: NEEDLES, HYPODERMIC
Class No.: 6515
(Federal Class Number)
Group: Medical and Surgical Instruments, Equipment and Supplies
(Federal Group Title)

KEY POINTS:

1. Luer Taper
2. Swaging of canula to hub
3. Point
   a. Burrs
   b. Tip
   c. Cutting edges
4. Canula
   a. Resistance to corrosion
   b. Resistance to breakage
   c. Resistance to bending

DIAGRAMS:

TESTS:

a. Leakage—Par e-2F (3) Fed. Spec. GGN-196
b. Resistance to breakage— Par E 2d Fed. Spec. GGN-196
c. Resistance to bending—Par E 2b Fed. Spec. GGN-196
d. Resistance to corrosion—Par E 2a (1) and Par E 2a (2) Fed. Spec. GGN-196
e. Luer Taper—ASA specs. Z70

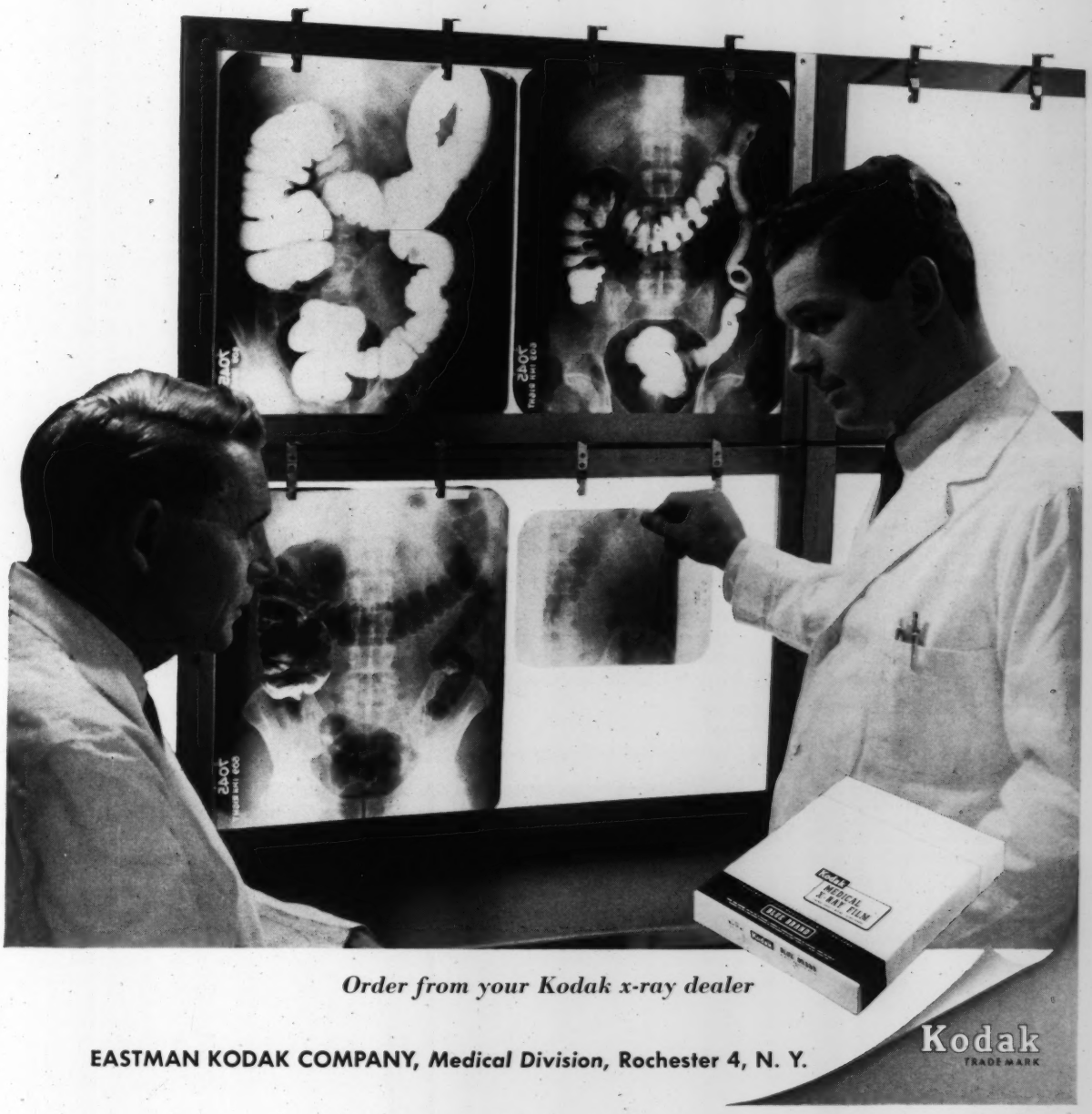
REMARKS:

REFERENCE: When ordering the above item, refer to the following for further details:

C.S. #
A.S.A. # Z70
F.S.S. # GGN-196
U.S.O. #
etc.

In double contrast studies...

for example—have you noticed how consistently Kodak Blue Brand X-ray Film provides clarity of detail throughout low-density areas? Blue Brand's uniformity of response, its contrast, and inherent low fog level make this possible.



Order from your Kodak x-ray dealer

EASTMAN KODAK COMPANY, *Medical Division*, Rochester 4, N. Y.

Kodak
TRADE MARK

equipment and supply review

Compact lavatory (2B-1)

Manufacturer's description: This combination toilet and washbasin cabinet was especially designed for hospital use. The unit is a fold-away type that can provide complete toilet facilities in patient rooms, outpatient rooms, x-ray

rooms and other areas where floor space is limited. Less than 10 square feet of floor space is required to provide a comfortable bathroom facility. One model includes paper towel and toilet tissue dispensers, waste receptacle and a concealed bedpan flusher if desired. Another unit offers a complete shower, washbasin, medicine cabinet, light fixture, and exhaust fan in one packaged unit, occupying a floor space of 31½ in. x 39 in. The units are shipped complete, ready for final hook-up to waste and water lines. Angelo Colonna, Inc., Dept. H, Westmorland Boudinot Sts., Philadelphia, Pa.

Lightweight photocopying machine (2B-2)

Manufacturer's description: This combination printer and processor is able to make an exact photocopy of any printed or written material in 30 seconds. It weighs 25 pounds and is constructed of stainless steel.

The machine can photocopy material that is up to 9 inches wide and of any length. A rheostat control on the top of the machine gives the operator flexibility in selecting the proper exposure for a particular original to be copied. Hunter Photo-Copyist, Dept. H, 595 Spencer St., Syracuse, N. Y.

> An endeavor is made to screen carefully the products appearing in this section. However, the statements printed have been made by the manufacturer and are brought to your attention primarily to keep you informed of new developments in the field. —The Editors.

Portable deodorizer (2B-3)

Manufacturer's description: This device not only provides efficient space deodorization, but at the same time keeps the air circulating by means of a silent twin-blower fan system which can be operated at high or low speed. The unit is supplied

with an air filter which helps purify the air it supplies, and contains four bottles of liquid deodorizer—enough to deodorize an area up to 1,000 sq. ft. for approximately 150 hours of continuous use. Aireactor Corp., Dept. H, 22 E. 40th St., New York 16. N.Y.

Pocket-size pH meter (2B-4)

Manufacturer's description: This versatile, low-priced pH meter accurately measures acidity and alkalinity using a combination electrode. Range of the meter is from 2 to 12 pH. The single electrode combines both the reference and

▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 18 E. Division St., Chicago 10, Ill.

PRODUCT NEWS

- _____ Compact lavatory (2B-1)
- _____ Lightweight photocopying machine (2B-2)
- _____ Portable deodorizer (2B-3)
- _____ Pocket-size pH meter (2B-4)
- _____ Wheel chair motor unit (2B-5)
- _____ Label holder (2B-6)
- _____ Plastic-topped folding tables (2B-7)
- _____ Plastic wrapping dispenser package (2B-8)
- _____ Counter refrigerators (2B-9)
- _____ Speedy x-ray processor (2B-10)
- _____ Enema disposable unit (2B-11)
- _____ Radioactive materials containers (2B-12)

PRODUCT LITERATURE

- _____ Blood chemistry manuals (2BL-1)
- _____ Steam heating specialties (2BL-2)
- _____ Medical gases (2BL-3)
- _____ Plastic food service covers (2BL-4)
- _____ Metal compartments (2BL-5)
- _____ Laboratory mixers (2BL-6)
- _____ Emergency lighting units (2BL-7)
- _____ Plastic reference (2BL-8)

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

(Please type or print in pencil)

make room for these two products– they'll make room for you

You will be amazed at the savings—not only in space but in reference time, filing efficiency and clerical costs – offered by these two fine products from Remington Rand.

CONVÉ-FILER with its 200,000 card capacity is ideal for housing the Master Patient Index. Operated by the touch of the toe or a finger (a push button selector is available) the tray containing the selected card is positioned electrically at convenient desk height. CONVÉ-FILER is the most efficient unit yet developed for a large active card file.

Patient Case Histories which present hospitals with their biggest record-keeping problem are no challenge at all to the FILM-A-RECORD Model 8 microfilm camera. With FILM-A-RECORD the contents of *160* four drawer filing cabinets can be reduced to microfilm and housed in a single ten drawer film storage cabinet measuring only five feet high and two feet wide. This versatile camera requires no more space than a typewriter yet produces the finest, most accurate microfilm results. If desired, frequently referred to histories can be filed in FILMSORT* jackets, combining space saving with fast filing reference.

*Filmsort is a registered trademark of DEXTER FOLDER CO.

Remington Rand

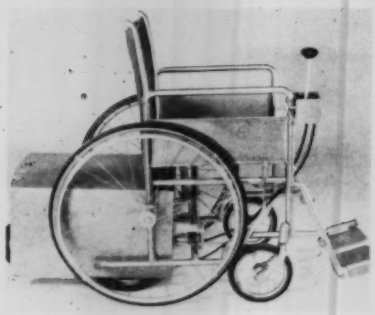
DIVISION OF SPERRY RAND CORPORATION

Write for FREE folders LBV160 (Convé-Filer) and CH1074 (Film-A-Record), Remington Rand, Room 1176, 315 Fourth Avenue, New York 10, N. Y.

glass electrodes and has been especially developed for use with the pocket pH meter. The instrument also has a "memory" dial for use in standardizing. The meter operates from simple, inexpensive batteries like those used in flashlights and hearing aids. Beckman Instruments, Inc., Scientific Instruments Div., Dept. H, 2500 Fullerton Rd., Fullerton, Calif.

Wheel chair motor unit (2B-5)

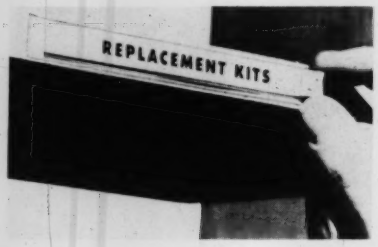
Manufacturer's description: A completely self-contained unit attaches to



most outdoor type tubular adult wheel chairs (8-in. front casters). The single adjustable arm control provides two forward speeds, one reverse speed, steering and smooth braking. A special automatic shut-off when the hand leaves the control for any reason is available. An additional low speed is provided for indoor use. Powered by two standard 6-volt batteries (not supplied) the unit will run 10-20 miles between charges. The motor unit can be coupled or uncoupled in one minute. General Medical Equipment Corp., Dept. H, 9 Cleveland St., Valley Stream, N.Y.

Label holder (2B-6)

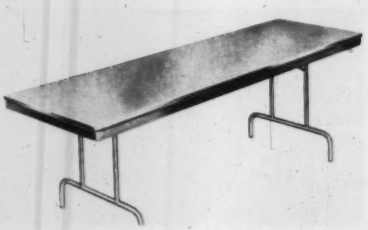
Manufacturer's description: All the things a hospital must keep track of—from patient to bags of beans—may be fitted into a simplified control or identification system consisting of a self-adhesive label-holder. A transparent window, cut to required size, holds an easily inserted label. It can be used on beds, in storerooms, and as components of wall charts which contain data that must be changed frequently. The label quickly sticks to any clean surface. Each six-inch strip makes three standard-size



label holders. There are three widths: 1 in., ¾ in., and ½ in. Cel-U-Dex Corp., Dept. H, 1 Main St., Brooklyn, N. Y.

Plastic-topped folding tables (2B-7)

Manufacturer's description: To meet the demand for a strong folding table, this company is now producing a series of plastic-topped tables made to resist the gouging, prying, and trenching to which folding table tops are subjected. Among the construction features of these tables are these: wide semibox type steel apron with die-formed round corners, reinforced with step-down gussets; flush-type extruded aluminum edge; steel center channel construction; and a patented auto-



matic leg lock that provides easy opening and folding of the table. Barricks Manufacturing Co., Dept. H, 134 W. 54th St., Chicago 9, Ill.

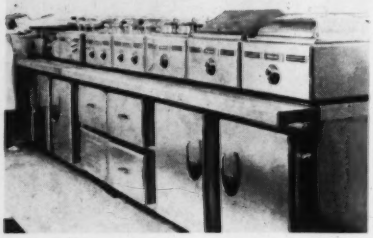
Plastic wrapping dispenser package (2B-8)

Manufacturer's description: A new dispenser package designed especially for use in hospitals is now being introduced. Available in both 12 in. and 18 in. widths, the Ready Roll is a 1,000 ft. roll of Saran Wrap packaged in a corrugated

cardboard dispenser box. It has been developed particularly for use in hospital kitchens for the covering of trays of food prepared in advance and the wrapping of meats and other items to be frozen. The Dow Chemical Co., Plastic Sales Division, Dept. H, Midland, Mich.

Counter refrigerators (2B-9)

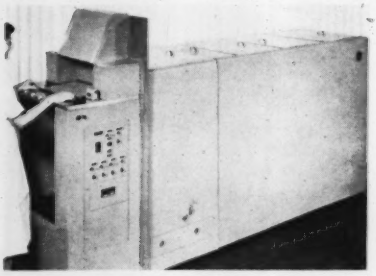
Manufacturer's description: With the addition of modern electric cooking



units, this 1957 line of welded all-aluminum counter refrigerators become "self-contained kitchens." The superstructure is completely wired and fused and contains outlets for electric cooking equipment —models available to house 3, 5, or 7 cooking units. The work tops are finished in consoweld with an oak cutting board. Also available are adjustable legs, glass doors and sliding refrigerator drawers. Foster Refrigerator Corp., Dept. H, Mill & North Second Sts., Hudson, N. Y.

Speedy x-ray processor (2B-10)

Manufacturer's description: The prototype of a radically new machine



that cuts to approximately six minutes the time needed to process Kodak x-ray film will be available

"MONTMARTRE" BY MAURICE UTRILLO

Paris, too, knows and uses Pentothal . . .

reflecting . . . a pattern of clinical usage followed the world over

Pentothal Sodium has been in the service of humanity for more than twenty years. In that time more than 2500 reports have been published on Pentothal, covering nearly every type of surgical procedure—making it unmistakably the world's most widely studied intravenous anesthetic. Reflected in these years of use and volumes of reports is a record unsurpassed for safety, effectiveness and versatility of use in intravenous anesthesia.

Abbott

PENTOTHAL® Sodium

(Thiopental Sodium for Injection, Abbott)

701013

no pain . . .
no memory . . .

No Nightmare of Fear

IN PEDIATRIC ANESTHESIA

How much more humane is today's pediatric surgical approach from the days when the child, filled with panic, was wheeled into the operating room.

For with Pentothal Sodium administered rectally, the child is never aware of the operating scene. He drops off, instead, into a dreamless sleep in the comfort of his own room and awakens there afterward with no memory of the events between.

Clinical reports on more than 4,000 cases attest to the effectiveness and humaneness of Pentothal by rectum. Used as a basal anesthetic or as the sole agent in selected minor procedures, Pentothal Sodium by rectum is easy to prepare and can be used safely for a wide range of patients. Do you have the literature? Abbott

PENTOTHAL® Sodium

(Thiopental Sodium, Abbott)

by rectum

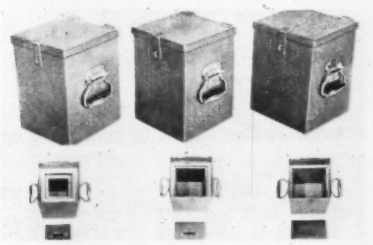
during the latter part of 1957. The new processor will deliver top quality radiographs in approximately six minutes—dry and ready for reading. Over-all length of the new processor is 10 feet and the machine takes up less than 25 square feet of floor area. In any sequence, all listed sizes of x-ray film sheets 5 x 7 in. and larger can be fed into the processor. Eastman Kodak Co., Dept. H, Rochester 4, N. Y.

Enema disposable unit (2B-11)

Manufacturer's description: Greater convenience and efficiency for hospital personnel using this enema disposable unit is afforded by a redesigned "hospital economy pack" that provides all materials for a single enema—squeeze bottle, rectal tube and lubricant—in a single package. A package containing 48 such units is now on the market. Each unit contains a new long-neck bottle and tapered rectal tube that permits easier administration of enemas. The patient's name and room number can be written on the package top in the space indicated. C. B. Fleet Co., Inc., Dept. H, Lynchburg, Va.

Radioactive materials containers (2B-12)

Manufacturer's description: Three safety accessories are designed for storing, shipping and transferring radioactive materials. Although the three models have the same outside dimensions of 8 x 8 x 10½ in., they differ in thickness of lead shielding and the choice of container should depend on the quantity and quality of radioactive material to be stored in it. The containers have offset lead liners which permit easy setting and removal of the inner lead cover—either by hand or by remote handling tongs. Construction and fittings are in accordance with the Bureau of Explosives regulations governing transfer cases for radioactive materials. The Atomic Center, Inc., Dept. H, 489 Fifth Ave., New York 17, N. Y.



product literature

(SEE COUPON, PAGE 64)

Blood chemistry manuals (2BL-1)—The laboratory supply division of Warner-Chilcott Laboratories has announced it will distribute a series of blood chemistry manuals to teaching institutions and laboratories. The manuals provide a ready reference and guide to laboratory workers and are designed to fit into a standard looseleaf binder. Warner-Chilcott Laboratories, Laboratory Supply Division, Dept. H, 113 W. 18th St., New York 11, N.Y.

Steam heating specialties (2BL-2)—This new eight-page catalog illustrates a complete line of steam heating specialties. These products include radiator valves, float and thermostatic radiator traps, inverted bucket traps, strainers, air eliminator air checks, and gauges for steam, oil, gas and water. Ask for Bulletin No. 1501A. Dunham-Bush, Inc., Dept. H, West Hartford, Conn.

Medical gases (2BL-3)—A new catalog on medical gases has been specially designed to serve as a teaching aid and reference source on inhalation anesthetic agents. A complete chart covering historical and clinical data on the inhalation anesthetic agents is included, as well as a full-color section illustrating all the standard cylinders and color coding. Ask for Form No. 4662. Ohio Chemical & Surgical Equipment Co., Dept. H, Madison 10, Wis.

Plastic food service covers (2BL-4)—This catalog sheet illustrates and describes plastic cake covers, platter covers, side dish covers and dinner plate covers. Size and ordering information is also given. Pikes Peak Plastics, Inc., Dept. H, Colorado Springs, Colo.

Metal compartments (2BL-5)—This 20-page catalog covers the entire line of toilet compartments, shower and dressing rooms, shower units and hospital cubicles made by this company. Actual color samples of the 20 standard colors available in porcelain enamel or baked-on finishes are included. All standard hardware and fittings are illustrated. The Mills Co., Dept. H, 951 Wayside Road, Cleveland 10, Ohio.

Laboratory mixers (2BL-6)—"Stirrers, Mixers & Shakers" is the title of a new 16-page booklet just published by this company. Complete descriptions and prices are given for a number of devices used for accomplishing these operations efficiently and automatically. Fisher Scientific Co., Dept. H, 717 Forbes St., Pittsburgh 19, Pa.

Emergency lighting units (2BL-7)—How fully automatic battery charge control enables these new emergency lighting units to give greater protection against lighting failures with less maintenance than ordinary units is outlined in this folder. The folder also contains an operation chart demonstrating the reliability of the automatic charge control device. Ask for Form 5926. Exide Industrial Division, The Electric Storage Battery Co., Dept. H, Box 8109, Philadelphia 1, Pa.

Plastics reference (2BL-8)—This 16-page booklet gives distinguishing characteristics, appropriate fabricating techniques, and major fields of application for each different group of plastics supplied by this company. Ask for "1957 Condensed Reference File." Bakelite Co., Division of Union Carbide and Carbon Corp., Dept. H, 30 E. 42nd St., New York 17, N. Y.

air conditioning the hospital

(Continued from page 53)

temperatures up to 80° F. The potential latent heat build-up of this area should not be overlooked.

As a protection against condensation, exhaust ducts from large hydrotherapy areas may require soldered joints or be otherwise watertight and should be graded and dripped to an open drain.

The exercise section will require no special treatment.

Generally, the recirculation of air of the physical therapy department is permissible and temperatures and humidities within the comfort range are recommended.

Occupational Therapy. In this department, space for activities such as weaving, braiding, art work, and sewing will require no special ventilation treatment. Recirculation of air is permissible.

Larger hospitals or those specializing in rehabilitation will have a greater diversification of skills and crafts, such as carpentry, metal work, plastics, photography, ceramics, painting and finishing of projects. Such a department will require specific study of the ventilating problem.

Pharmacy. This area will be treated for comfort and will require no special ventilation.

NURSERY

Full-Term Nursery. A temperature of 75° F. and a relative humidity of 50 per cent are recommended for the full-term nursery, examination room and work space *(32)*. It is necessary that similar conditions be maintained in all of these areas, as care of full-term infants requires that they be moved periodically from the nursery to the work space and examination room. The maternity nursing section should be treated similarly to protect the infant against temperature changes during visits with the mother.

Premature Nursery. The premature nursery will require temperatures of 80° F. and a relative humidity range of 55 to 65 per cent. Although it will be equipped with individual incubators which provide close regulation of temperature and humidities, these conditions must be maintained in the area to accommodate the infant who is removed from the incubator.

Observation Nursery. The observation nursery will require a temperature of 75° F. and 50 per cent relative humidity. The air of the observation nursery should not be recirculated.

In order to provide maximum safety for the newborn, whose resistance to infection is normally low, the following conditions should be adhered to in the ventilation of all nursery areas:

1. The entire nursery should be pressurized to prevent the entry of contaminated air from outside areas.
2. An equivalent of three air changes per hour of outdoor air should be supplied.
3. Nursery air, with the exception of the observation nursery, may be recirculated within the nursery when properly filtered.
4. Air from the observation nursery should not be recirculated; it should be discharged to the outside.
5. Air distribution within the area should be carefully planned, and air velocities at floor level should not exceed 25 feet per minute.
6. Air from other areas of the hospital should not be circulated through the nurseries under any circumstances.

NURSING DEPARTMENT

Patient Rooms. Because of the ever-present possibility of cross-infection, particularly of the respiratory tract, and to prevent the spread of odors, it is desirable that air circulation be confined to the individual rooms of this area. However, patient room air may be recirculated through a central conditioning system and be redistributed to the patient rooms with an acceptable degree of safety if properly filtered. A temperature of 75° F. and relative humidity of 45 to 50 per cent are recommended for all rooms of this area.

A minimum ventilation rate of one and one half air changes per hour is recommended for patient rooms. The ventilation of toilets, bedpan closets, and all interior rooms and bathrooms should conform to local codes.

Isolation Unit. The isolation unit air exhaust system should provide for outboard exhaust of all air when the area is used for contagious disease or odorous cases and for recirculation of air when not

QUIET Enters the Hospital

Semi-private room in the Indianapolis Community Hospital, Indianapolis, Ind., showing ceiling installation of Acousti-Celotex incombustible Random Pattern Mineral Fiber Tile.* **Architect:** Daggett, Naegele & Daggett. **Acousti-Celotex Contractor:** Hugh J. Baker & Co.

Recognized aid to patient recovery and personnel morale: Sound-conditioning hospital ceilings with Acousti-Celotex Tile! These carefully-engineered ceilings arrest noise in corridors, lobbies, kitchens, service areas, wards, nurseries, operating and delivery rooms.

Quiet comfort results . . . speeding patient convalescence, providing pleasant working environment for hospital staff. **Mail Coupon Today** for a *free analysis* of your hospital's noise problem . . . plus free factual booklet.

*PAT. NO. D-168,763

ACOUSTI-CELOTEX
REGISTERED U. S. PAT. OFF.
TRADE MARK

Sound Conditioning

Products to Meet Every Sound Conditioning Problem . . . Every Building Code—The Celotex Corporation, 120 S. LaSalle St., Chicago 3, Illinois • **In Canada:** Dominion Sound Equipments, Ltd., Montreal, Quebec

MAIL NOW

The Celotex Corporation, Dept. F-17
120 South LaSalle Street, Chicago 3, Illinois

Without cost or obligation, please send me the Acousti-Celotex Sound Conditioning Survey Chart, and your booklet, "The Quiet Hospital."

Name_____ Title_____

Institution_____

Address_____

City_____ Zone_____ State_____

used for this purpose. A minimum ventilation rate of three air changes per hour with a negative air pressure is indicated for this area. Room unit conditioners which induce a flow of air through the unit are not recommended for this area because of the necessity for the periodic decontamination of coils.

Treatment Rooms. The treatment room may require special ventilation, depending upon the nursing area specialty or type of work to be performed in the room. Usual practice will require four air changes per hour, with temperatures up to 80° F.

Floor Pantry. Ventilation requirements of this area will depend upon the type of food service adopted by the hospital. Where bulk food is dispensed and dishwashing facilities are provided in the pantry, the use of hoods with exhaust to the outside is recommended. Small pantries used for between-meal feedings will require no special ventilation. A negative pressure in the area will reduce the spread of odors.

SURGICAL DEPARTMENT

The operating rooms, including cystoscopic, fracture, and induction rooms, will require careful design to reduce the hazards of infection and explosion *(24,25,26)*.

Operating Rooms. It is the opinion of some authorities that one of the most dangerous potential sources of surgical infection is the pathogenic bacteria given off from noses and throats of occupants of modern well-run operating rooms *(1, 25,26, 54,55)*. Air disinfection to remove or destroy this source of infection is generally accomplished by ventilation and in some cases by bactericidal irradiation.

Ventilation of the operating rooms as a dilutant or medium for the removal of organisms is the generally accepted installation in modern hospital practice. As a means of reducing surgical infections, this practice has some substantiation by reports of studies of the subject *(8,11,12,54,57)*. Ventilation is accomplished by introducing 100 per cent of filtered outdoor air, preferably taken from above the roof, to the operating room at a rate of 8 to 12 air changes per hour with 10 air changes recommended. This ventilation rate also reduces the concentration of anesthetic gases, thus diminishing the possibilities of explosions and providing a more agreeable atmosphere for the operating team.

At the present time there is some feeling among authorities that recirculating a portion of the air of the operating rooms does not constitute a hazard to the patient. No reports of investigations as to the cumulative effect of recirculation on the bacterial concentration in operating rooms have come to our attention. Until such time as investigations prove otherwise, it is considered to be in the best interest of the patient to provide 100 per cent fresh air with no recirculation.

Although very dramatic results relative to air disinfection of operating rooms by irradiation have been reported *(2,25)*, this method of disinfection has not been generally applied. The reluctance to use irradiation may be accounted for by such factors as special designs required for installation, protective measures necessary for patients and personnel, constant vigilance relative to lamp output, and the maintenance required.

The following conditions are recommended for operating cystoscopic and fracture rooms:

1. Temperature of from 72° F. to 76° F. as required by the surgeon.
2. Relative humidity of 55 per cent to reduce the hazard of static spark.
3. Ten air changes per hour.
4. One hundred per cent fresh filtered air.
5. No recirculation of operating room air during the time operating rooms are in use.
6. A positive pressure within the operating room to prohibit the entry of air from the corridor or other unsterile areas.
7. Exhaust air taken off from a point near the floor to remove dust and the heavy anesthetic gases.
8. Installation to conform to that portion of NFPA Bulletin No. 56 ("Recommended Safe Practice for Hospital Operating Rooms") which pertains to explosion hazards.

In order to provide maximum safety for the patient and to conform to the above recommendations, a separate system will be required to serve the operating rooms. The system may be designed to permit recirculation of air during periods when the operating rooms are not in use. Controls governing recirculation of the air should be conveniently located so as to be available to the surgical supervisor at all times; in addition, a visual signal indicating whether the system is recirculating should be prominently located.

Recovery Rooms. Recovery rooms used in conjunction with operating rooms should provide approximately the same temperature and humidity as the operating rooms so that the patient will not be subjected to any radical change in environment during immediate postoperative recuperation. As anesthesia gas and nausea resulting from anesthesia sometimes create an odor problem in recovery rooms, a ventilation rate of three air changes per hour is recommended. The air of the recovery rooms may be recirculated if properly filtered.

Anesthesia Storage. The anesthesia storage room should be ventilated at a rate of two air changes per hour to conform to the regulations set down in NFRA Bulletin No. 56.

Central Sterilizing and Supply. The central sterilizing and supply rooms present no particular problem and comfort requirements of personnel are the prime consideration.

The following items are important:

1. The insulation of sterilizers in these areas will materially reduce the heat load.
2. Sterilizer equipment closets should be amply ventilated to remove excess heat.
3. Air exhaust grilles or hoods, located immediately above sterilizer doors, will assist in voiding excess heat and steam and will protect wall and ceiling finishes.

OBSTETRICAL DEPARTMENT

The system design for this department should be patterned after that of the surgical department. Recommendations for operating rooms will apply to delivery rooms.

EMERGENCY DEPARTMENT

The emergency operating rooms should be treated the same as the

NCG has done it again...and this time it's TWINS

ORDER NOW!

TWO new Flowmeters

made of strong green NYLON

1. FOR GENERAL USE, O to 15 LITERS
2. FOR NURSERIES, O to 5 LITERS

Shown above in actual size and colors. Turn page for details... NCG®

The new NCG Flowmeters

Modern Materials
Modern Design
Modern Performance

Everything a Flowmeter should have—plus new beauty no Flowmeter has ever had before. NCG has combined modern design and material in another "first" that will make hospital history.

Made of strong green nylon, with clear gauge panels of Lucite*. Lightweight, compact, easy to read, and extremely accurate. Pressure compensated to provide a uniform, unvarying flow of oxygen. And you can tell *exactly* what the flow is, because the thermometer-type indicator can be read at only one point regardless of the angle of vision.

The new Flowmeters have only two moving parts: the float assembly and the needle valve assembly. The valve stem seats against nylon, assuring minimum maintenance. Rugged, safe, easy to connect and adjust. Can be used with all piped oxygen systems to regulate flow through all types of equipment.

Your NCG representative is ready to demonstrate the new Flowmeters for you. Phone or write the nearest NCG office.

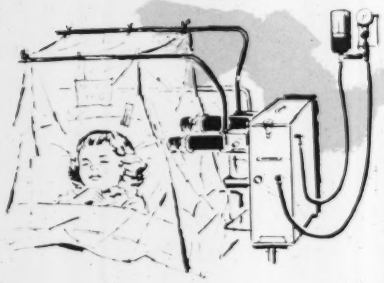
No. 24980 Regular Model. Flow is gauged from 0 to 15 liters of oxygen per minute. Open Needle Valve to flood for building up a quick concentration.

No. 24981 Nursery Model. Flow is gauged from 0 to 5 liters of oxygen per minute. Gives an accurate control of oxygen flow into incubators.

* Body of Flowmeter is made of Du Pont "ZYTEL" nylon resin. Gauge panel is made of Du Pont "LUCITE" acrylic resin.

for universal use with

MASKS



TENTS

CATHETERS, CANNULAS

and INCUBATORS

ORDER NOW!

NCG®

NATIONAL CYLINDER GAS COMPANY

840 North Michigan • Chicago 11 • Dept. 102

Offices in 56 Cities

Copyright 1956, National Cylinder Gas Company

operating rooms in surgery. Observation bed space should conform to the requirements of patient rooms in the hospital. Office and waiting rooms will be treated for comfort.

SERVICE DEPARTMENT

Service areas include dietary, housekeeping, mechanical, and employees' facilities. With the exception of employees' facilities, these areas are not usually cooled, but adequate ventilation is important to provide sanitation and a wholesome environment. Ventilation of these areas cannot be limited to exhaust systems only; provision for supply air must be incorporated in the design. The best designed exhaust system may prove ineffective with an inadequate air supply. Experience has shown that reliance on open windows results only in dissatisfaction during the heating season. The incorporation of air to air heat exchangers in the general ventilation system, other than range hood exhaust, offers possibilities for economical operation in these areas *(61)*.

Dietary Facilities. In this area the main kitchen, bakery, dietitians' office, dishwashing room, and dining space will require care in design.

Kitchen—The ventilation should conform to local codes, but in the absence of such codes, a minimum of 10 air changes per hour is recommended.

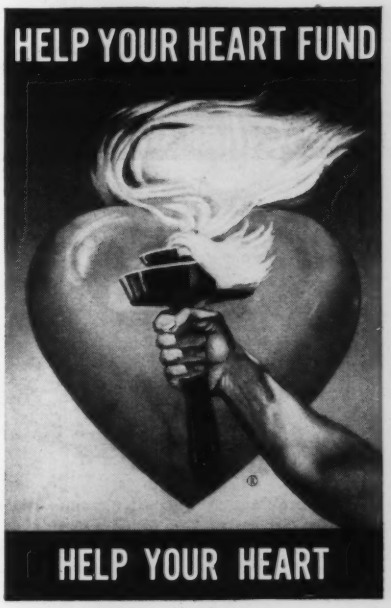
Such cooking equipment as broilers, ovens, ranges, kettles, and steamers are generally grouped for efficient utilization. The area serving this equipment should be vented through a hood to remove heat, odor, and vapors. The ventilation rate through the hood will vary according to design and mounting height *(28)*, but a rate of 100 cubic feet per minute per square foot of hood opening is very often used with conventional hoods, mounted 6 feet 6 inches from the floor. Hoods over cooking equipment should be equipped with grease filters to remove any grease from the vapors before they enter the duct system. Condensed greases in duct systems are a potential fire hazard.

Safety measures should be incorporated in the design to protect the duct system against fires originating over the stove. Such protection is usually accomplished by one or more of the following: a steam line to the throat of the hood at the duct connection for smothering action, CO_2 outlets at the hood perimeter, or fusible link dampers.

The hood exhaust fan should be selected to provide the air volume required over the range of filter resistances. These resistances will increase greatly as the filters become fouled. The location of the system air supply inlets relative to hood exhaust is important to eliminate the possibility of short circuiting between supply and exhaust. Where dietary facilities are located within the hospital structure, exhaust ventilating air should be discharged above the roof.

Dietitians' Office—This office is often located within the main kitchen or immediately adjacent to it. It is usually completely enclosed to insure privacy and quiet and will therefore require positive ventilation.

Dishwashing Room—Because of steam and heat liberated, this area will require the same ventilation rate as the kitchen. Depending upon size of the area, all or the greatest part of exhaust air may be taken off through the dishwasher hood, which eliminates dissemination of humid air throughout the area. Exhaust ductwork should be noncorrosive and watertight to handle condensation of steam and should be graded and dripped to a convenient drain.



Dining Space—The ventilation of this space will conform to local codes. Where cafeteria service is provided, serving areas and steam tables are usually hooded. Hood air handling capacities will be somewhat less than those required for the cooking area.

Housekeeping Facilities. Of these facilities, the soiled linen rooms and laundry only will require special attention.

Soiled Linen Storage Room—As a storage space prior to laundering, this room is subject to odors from used linens and will require ventilation at a rate of not less than eight air changes per hour.

Laundry—Ventilation should conform to local codes, but in the absence of such codes, a minimum of 10 air changes per hour is recommended.

The design of laundry ventilation systems seldom receives the study necessary to provide proper safeguards against the recontamination of linen during the cleaning process by airborne organisms.

The activities associated with sorting linen and loading washers are reported to add heavily to the contamination of the laundry air. This contaminated air is then drawn through extractors and tumblers where the linen acts as a filter and collects the organisms. It is reported many of these organisms survive the heat of the ironing process *(35,36,38)*.

To reduce the contamination of the laundry air, it is recommended that the sorting of linen be done in an enclosed area separated from the main laundry. This area will require eight air changes per hour and should be maintained at a negative pressure by the ventilation system.

Of the various laundry equipment, the flatwork ironer produces the greatest amount of heat and vapor. It is the usual practice to install a canopy over the ironer to concentrate and remove the heat immediately at this point. Most laundry layouts permit the greatest part of the exhaust to be discharged through the canopy, although some exhaust should be provided over the washers to remove heat and vapors originating from this equipment. The exhaust

CRA

New...the first and only bedpan washer with a "no-drip" nozzle

Doesn't have to be drained after using

You know what happens if a nurse or nurse's aide forgets to drain the ordinary bedpan washer after she's finished with it. Water drips over the floor and someone has to take time to clean it up.

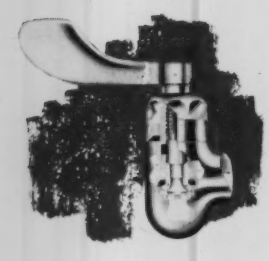
But not with the Crane bedpan washer. It meets all the latest plumbing sanitary requirements and yet doesn't drip. The secret is a spray nozzle with an exclusive "no-drip" feature. It stops the dripping before it has a chance to start.

For complete information see your Architect or Crane Representative. Find out how Crane specialization can save your hospital time and money.

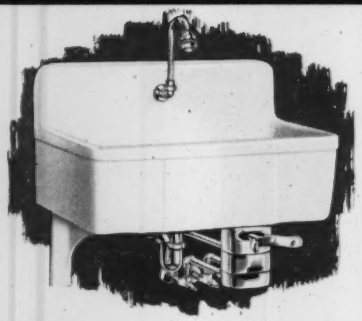
CRANE CO. 836 South Michigan Ave. Chicago 5, Illinois

VALVES • FITTINGS • PIPE • PLUMBING • KITCHENS • HEATING • AIR CONDITIONING

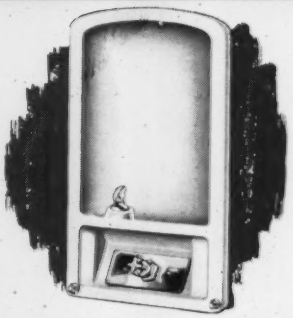
Do You Have These Other Crane Exclusives in Your Hospital?



Dial-ese controls on all plumbing fixtures. *Minimize dripping. Close with water pressure. Threads permanently lubricated. Working unit replaced in about 10 seconds.*



Duraclay. *A special vitreous glazed earthenware for large hospital fixtures. Won't crack or craze under thermal shock. Available in white or seven Crane colors.*



Corridor Drinking Fountain. *Fully recessed type leaves hall area clear . . . nothing to clean under. Available with single Wal-Pak or central water chiller for up to sixty installations.*

NE

The Preferred Plumbing

from tumblers should be carried away independent of the general exhaust system. This exhaust may require lint filters in addition to those on the tumbler. All laundry exhaust should be carried to a point above the roof or to an outlet where it will not be obnoxious to other areas of the hospital. It should not be in close proximity to fresh air ventilation intakes.

Fresh air supply is a requisite to good ventilation of this area and distribution designed to avoid short circuiting is important. The design may lend itself to the use of air to air heat exchangers for economy of operation *(61)*.

Mechanical Facilities. *Boiler Room*—Ordinarily too little attention is given to proper ventilation of the boiler room. Exhaust ventilating fans which compete with the boilers and the chimney for an insufficient air supply are not uncommon. The air supply to boiler rooms should be computed on the basis of providing both comfortable working conditions and the air quantities required for maximum combustion rates of the particular fuel. Boiler and burner ratings will establish maximum combustion rates, and air quantities can be computed according to the type of fuel. Approximate quantities of air required per unit of fuel are as follows: Natural gas, 10 cubic feet per cubic foot of gas; oil, 1,500 cubic feet per gallon of oil; bituminous coal, 133 cubic feet per pound of coal.

Maintenance Shops—Carpentry, machine, electrical, and plumbing shops present no particular difficulties, but the ventilation of paint shops and paint storage areas is very important and should conform to local codes.

Employees' Facilities. These rooms will be treated to provide comfort and to conform to local codes. ■

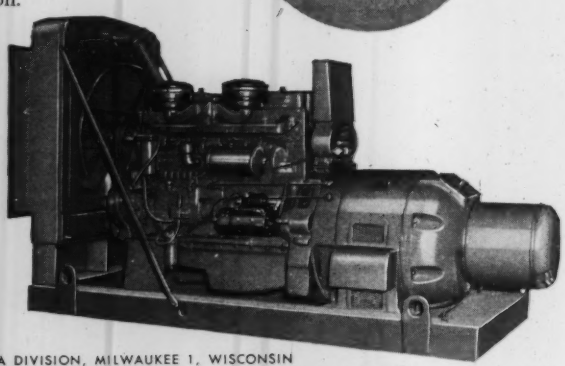
DON'T LET A POWER FAILURE STAY THE SURGEON'S HAND

Rely on Allis-Chalmers Engine Generating Sets

Undivided Responsibility — Allis-Chalmers generating sets are backed by the company's long reputation for building dependable engines and electrical equipment. Responsibility is centered in *one* organization—important through the set's entire operating life.

Wide Choice of Models and Fuels — Allis-Chalmers offers sets with capacities from 5 to 300 kw. Engines operate on diesel fuel, gasoline, natural or LP gas. Each unit is mounted on a welded steel base, requires no special foundation.

Complete Service — Look to Allis-Chalmers for consultation on your power requirements, recommendations based on long experience, with proper installation and servicing as required. Call your Allis-Chalmers engine dealer or write for detailed information.



100-kw diesel engine generating set. Many other models also available to fit any requirement.

ALLIS-CHALMERS, BUDA DIVISION, MILWAUKEE 1, WISCONSIN

ALLIS-CHALMERS

BG-11

REFERENCES

Editor's Note: The complete reference list for this two-part article was printed at the end of Part 1, which appeared in the January 1 issue of the Journal. The list below includes only references cited in Part 2.

1. Lowbury, E. J. L. Cross-infection of wounds with antibiotic-resistant organisms. *Brit.M.J.* 4920:985 April 23, 1955.
2. Wells W. F. *Airborne Contagion and Air Hygiene.* Harvard University Press, 1955.
8. Yaglou, C. P., Wilson, U. Disinfection of air by air conditioning processes. *Aerobiology* American Association for the Advancement of Science, Publ. No. 17, 1942.
11. Bourdillon, R. B., Colebrook, L. Air hygiene in dressing rooms for burns or major wounds. *Lancet* 6399:561 April 26, 1946.
12. Lowbury, E. J. W. Air conditioning with filtered air for dressing burns. *Lancet* 6806:292 Feb. 6, 1954.
24. Walters, C. W. *Aspetic Treatment of Wounds. The MacMillan Co.,* New York 1948, pp.188-189.
25. Hart, D., Operating room infection. *Arch.Surg.* 34.874 May 1937.
26. Hart, D., Schiebel, H. M. Role of the respiratory tract in contamination of air. *Arch.Surg.* 38:788 April 1939.
28. Dalla Valle, J. M. Design of kitchen range hoods. *Heating-Ventilating* 50:8 Aug. 1953.
32. American Academy of Pediatrics. *Hospital Care of Newborn Infants.* Evanston, The Academy, 1954. 144 pp.
35. Felsen, J. Lapin, J., Wolarsky, W. Weil, A. J. Fox, I. Staphylococcic infections in hospital nurseries and pediatrics wards. *Am.J.Dis.Child.* 81:534 195.
36. Wallace, A. T., Dugid, J. P. Staphylococcus aureus air infection in a maternity hospital. *Edinbury Med.J.* 59:200 1952.
38. Church, B. D., Loosli, C. G. The role of the laundry in the recontamination of washed bedding. *J.Infect.Dis.* 93:65 July-Aug. 1953.
52. Decker, H. M., Citek, F. J., Harstad, J. B., Gross, N. H., Piper F. J. Time temperature studies of spore penetration through an electric air sterilizer. *Applied Microbiology* Vol. 2 No. 1, Jan. 1954.
54. Blowers, R., Maston, G. A., Wallace, K. R., Walton, M. Control of wound infection in a thoracic surgery unit. *Lancet* Oct. 15, 1955 pp. 786.
55. Infections occurring in the hospital (editorial). *J.A.M.A.* Vol. 160 No. 4, Jan. 28, 1956.
57. Girdlestone, G. R., Bourdillon, R. B., MacFarlan, A. M. Infection of clean surgical wounds by the surgeon and from the air. *Lancet* March 17 1951.
61. Goddard, K. R. Air conditioning: Savannah Memorial Hospital. *Prog. Arch.* July 1954.

For further general reference on the physiological and engineering aspects of air conditioning system design: the *Guide* published by the American Society of Heating and Air Conditioning Engineers; *Refrigerating Data Book* published by the American Society of Refrigerating Engineers.

(No. 80-62 PRIVATE ROOM GROUPING)

Another Hill-Rom First — series 8,000 hospital furniture

color styled by Howard Ketcham

Hill-Rom
Contemporary
FURNITURE FOR THE MODERN HOSPITAL

• This beautiful private room grouping is a happy combination of the traditional and the modern in hospital furniture design and finish. A distinctive feature is the decorative line which curves gracefully across the panel parts to contrast pleasingly with the deep, luxurious finish of the wood as fashioned by our color expert.

All posts and framework are of solid maple. The panel work is cherry wood. Tops of chest desk, overbed table and bedside cabinet are high pressure laminate—cherry grained, heat and stain resistant. Although classed as a minimum priced suite, the 8,000 grouping is a Hill-Rom creation in every respect, which means it has been built for value and durability as well as for smartness and beauty.

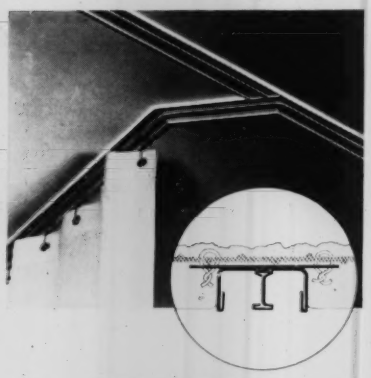
Shown in the 80-62 Private Room Grouping above are: No. 80-62 Motor Hilow Bed (listed by U.L. for use with oxygen) No. 8003 Bedside Cabinet, No. 80-614 Overbed Table, No. 80-26 Chest Desk, No. 8007 Straight Chair, No. 8008 Arm Chair, No. 306 Lamp and No. 300 Safety Sides. The No. 80-61 Manual Hilow Bed is also available with this grouping.

Write or wire for further information on this grouping.

HILL-ROM COMPANY, INC. • BATESVILLE, INDIANA

NOW . . . for

New Construction and Remodeling Jobs



HILL-ROM Recessed-in-Ceiling Screening

- No Rod Supports
- No Wall Brackets
- Exclusive I-Beam Track

Hill-Rom recessed-in-ceiling Perfected Screening provides for insertion of the track directly into the ceiling, leaving no exposed fixtures or projections. Designed primarily for use in new construction, or when remodeling is being done. The track is wired directly to the metal lath and stringers—before plastering. Plaster is applied flush with the track. Channel and track may be painted to match ceiling finish, making an installation that is hardly noticeable. This type of screening can also be used with accoustical tile applications.

STANDARD CURTAINS

By using the standard Hill-Rom screening unit (either type) one-size curtains are used throughout the building. This eliminates confusion when replacing curtains after laundering. Hill-Rom curtains are made of pre-shrunk, vat-dyed Cordette material, in 16′ width, length determined by ceiling height. The rollers are made of machined nylon, insuring quiet operation. Rollers and curtain hooks are assembled in one unit.

Now.. Hill-Rom Safety Curtains

Flame-proof... Washable

● Hill-Rom, long known for its many contributions to safety in hospitals, is happy to present another "Safety First" item of equipment to the hospitals of America—a Flame-proof Curtain for Cubicle Screening.

The above illustration is from an actual photograph, and shows a test you can make in your own hospital. Hold the flame from a cigarette lighter or lighted match directly against a Hill-Rom Flame-proof Curtain. The cloth will not support a flame. It will only char.

Hill-Rom Cordette, the material used in these curtains, is made flame-proof with a proven chemical process in which the chemicals actually become a part of the yarn. They also tend to increase the tensile strength and abrasive resistance of the fabric. The curtains will withstand repeated launderings without loss of the flame-proof qualities. Neither the color nor "feel" of the fabric is affected. Actually, it will be *softer* after the initial laundering.

Hill-Rom Flame-proof Curtains are available in cream, peach and green shades. Complete information and samples of the flame-proofed material will be sent on request.

HILL-ROM **PERFECTED** Screening

HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

personal news

● ROBERT J. ANDERSON, M.D., has been appointed chief of the Public Health Service's Communicable Disease Center, Atlanta, Ga. Dr. Anderson succeeds THEODORE J. BAUER, M.D., who will become deputy chief of the Bureau of State Services in the Washington headquarters of the PHS.

Dr. Anderson is presently assistant chief of the Division of Special Health Services in Washington. For the past two years he has directed operational research in tuberculosis, chronic diseases, venereal disease, occupational health, and heart disease control activities.

● REV. ROBERT S. BAZZELL has been appointed administrator of Oklahoma Baptist Hospital, Muskogee, Okla. He was formerly administrator of Perry (Okla.) Memorial Hospital. The Rev. Mr. Bazzell succeeds J. F. MURRELL who retired January 1.

REV. BAZZELL

REV. GEORGE L. HART succeeds the Rev. Mr. Bazzell at Perry Memorial Hospital. He was formerly administrator of Southwest Baptist Hospital, Mangum, Okla.

● GRAHAM L. DAVIS has been appointed administrator of Onslow County Hospital, Jacksonville, N.C. He succeeds GEORGE I. RENTZ who has been appointed assistant administrator of South Carolina Baptist Hospital, Columbia, S.C.

Mr. Davis, formerly a hospital consultant, served as president of the AHA in 1948.

● JOHN E. GORRELL, M.D. is returning to full-time consultation in hospital administration and community health studies. He was professor of hospital administration in the School of Public Health, Columbia University, from 1945-53. For the past three years he has been consultant to and director of medical services for the National Foundation for Infantile Paralysis, New York.

● TERRY HIERS JR., has been appointed administrator of Americus (Ga.) and Sumter County Hospital. He succeeds GEORGE E. LINNEY. Mr. Hiers was formerly assistant administrator of Baptist Hospital, Nashville, Tenn.

● H. W. MCCOMAS has been appointed superintendent of Garrett County Memorial Hospital, Oakland, Md. He was formerly director of social service and hospital revenue investigator of the Baltimore City Hospitals.

● NEIL MCGINNISS has been appointed director of Oakwood Hospital, Dearborn, Mich. He succeeds JACQUES COUSIN, who has been appointed executive director of the newly reorganized Greater Detroit Area Hospital Council.

MR. McGINNISS

MR. COUSIN

Mr. McGinniss was formerly assistant director of Oakwood Hospital. He is a graduate of the Columbia University course in hospital administration.

● ARNOLD E. MOUISH has been appointed assistant manager of the Veterans Administration Consolidated-Newington Hospital, Newington, Conn. Mr. Mouish was formerly special assistant to the manager of Veterans Administration Hospital, Northport, L.I., N.Y.

MR. MOUISH

He is a graduate of the Northwestern University program in hospital administration.

● HARRY B. ROBY has been appointed administrator of Primary Children's Hospital, Salt Lake City, Utah. Mr. Roby recently retired from the Navy after completing approximately 22 years of service, mainly in the field of medical administrative work.

● ANDREW W. SAPHILOFF has been appointed administrative services director of the Commonwealth of Virginia's mental hospital, Petersburg, Va. He was formerly administrator of the John Graves Ford Memorial Hospital Georgetown, Ky.

MR. SAPHILOFF

Mr. Saphiloff is a graduate of the Northwestern University program in hospital administration.

● SISTER M. BATHILDIS, S.P.S.F., has been appointed administrator of St. Anthony Hospital, Columbus, Ohio. She was formerly administrator of St. Elizabeth Hospital, Dayton, Ohio.

SISTER M. BERNARDINE, S.P.S.F., formerly administrator of St. Anthony Hospital has been appointed administrator of St. Elizabeth Hospital.

● SISTER M. ELIZABETH, S.P.S.F., has been appointed administrator of St. Mary's Hospital, Cincinnati. She was formerly assistant administrator and chief medical technologist at St. Elizabeth Hospital, Dayton, Ohio.

● COL. JOSEPH C. THOMPSON has been appointed commanding officer of William Beaumont Army Hospital, El Paso, Tex. He was formerly executive officer of Ft. Hood and Ft. Polk, La.

● ARTHUR G. TURNER has been appointed administrator of a new hospital under construction in East Whittier, Calif. He was formerly administrator of the Kaiser Foundation Hospitals, Fontana, Calif.

Mr. Turner will assist with planning construction and staffing prior to the scheduled opening of the new hospital in March 1957.

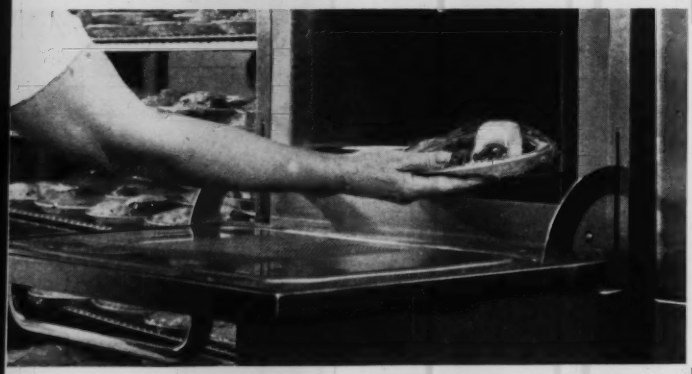
(Death Notices on page 98)

food service and dietetics

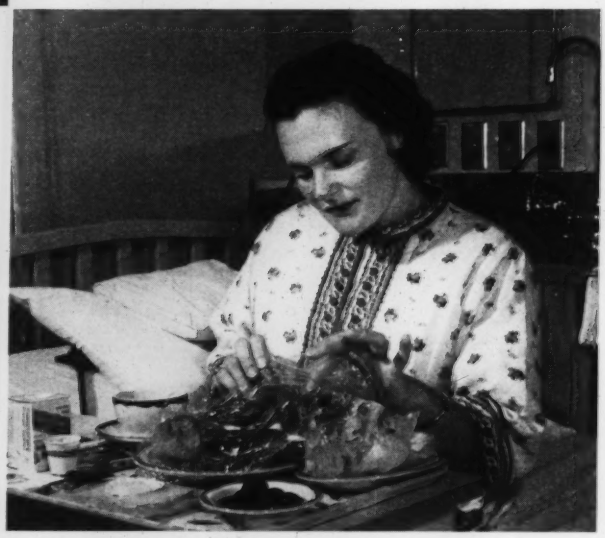
we cook with microwaves

a group of California hospitals reports preparation of food in microwave ovens reduced their raw food and labor costs

by E. R. PARK



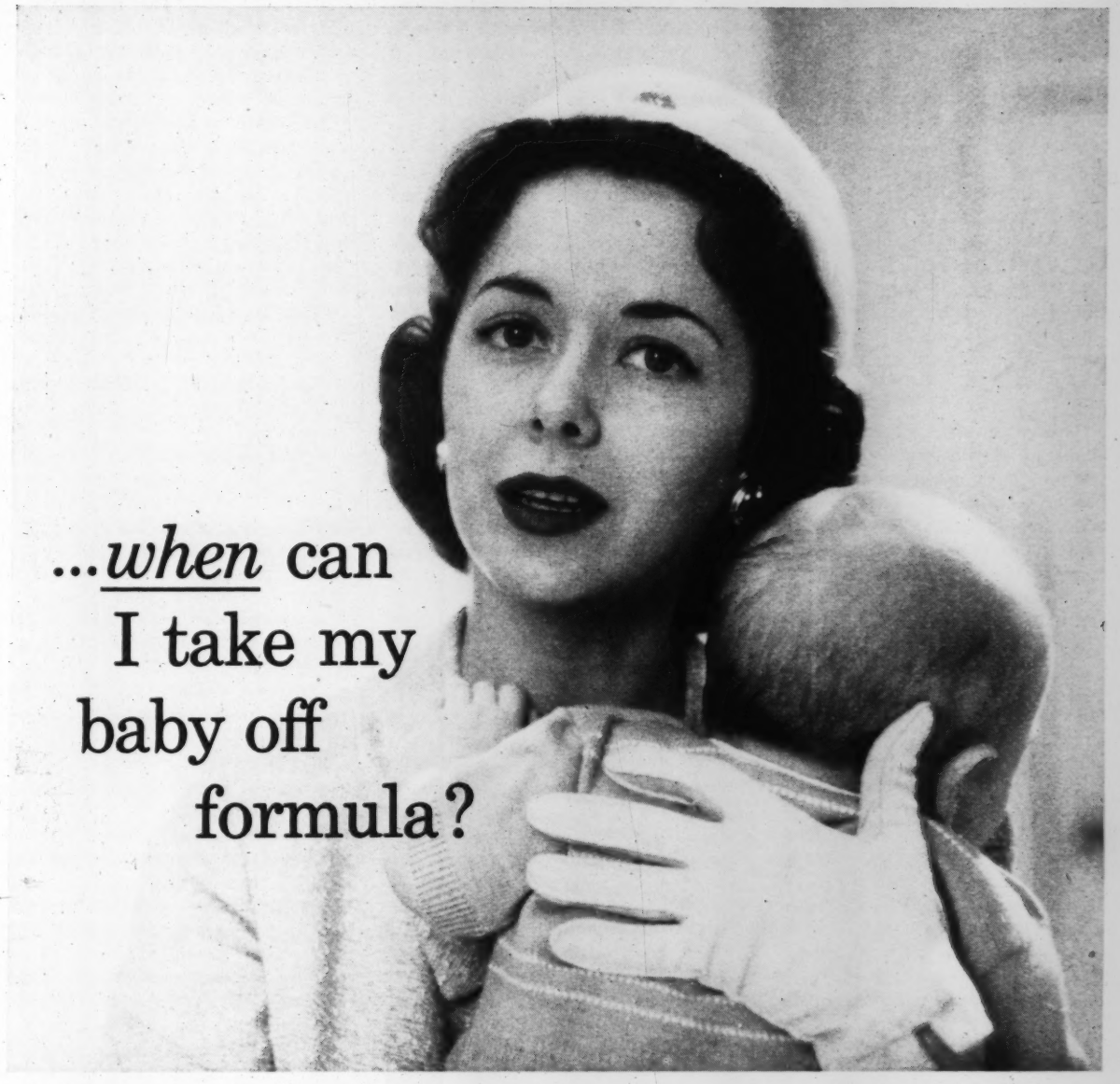
(ABOVE) THIRTY minutes before serving time frozen, precooked items are placed on the hot plates, covered with a transparent wrapping and stored on shelves adjacent to the microwave ovens. Canned soup is portioned into bouillon cups and stored on trays. (LEFT) AT service time food service employee sets the automatic timer for the required number of seconds, places one "hot" plate and cup of soup into the oven cavity at a time, closes the door, presses the starter button, and in less than one minute a piping hot dinner is ready for the patient. The cup of soup is covered with a stainless steel lid. The cup and hot plate are then placed in the heated section of the food cart corresponding to the order in which the tray was placed in the cart. (BELOW) HOT PLATE and the corresponding tray with cold items are combined and the tray is delivered to the patient. Most patients prefer to remove the covering themselves, although the nurse will remove it, if desired.



HOSPITALS throughout the country are continually revamping their systems of food service in an effort to provide hotter and more palatable meals to patients more economically. This is an important consideration when one realizes food service is one of the largest single expenses in the hospital's total operating budget. Realizing this fact, Sidney R. Garfield, M.D., founder of the Kaiser Foundation Hospitals' concept of operation, during the past several years personally directed many of his staff in quest of a better system of food service. The work accomplished several years ago paved the way for our present use of microwave ovens in Kaiser Foundation Hospitals in California.

In 1952 a test was undertaken at one of our hospitals to determine the advantages and disadvantages of a centralized tray service using thermal, vacuum-sealed, insulated containers and tray trucks with hot or cold sections versus the centralized bulk method, whereby portable steam tables are used to transport food in bulk to the floor serving areas. We found the centralized method using vacuum-sealed containers

E. R. Park is administrative dietary consultant, Kaiser Foundation Hospital, Oakland, Calif. This article was developed in collaboration with the following staff members of Kaiser Foundation Hospitals in California: W. F. Day, administrative coordinator, Kaiser Foundation Hospitals, Northern California; Francis G. Miles, chief dietitian at the Walnut Creek hospital; Lucille Foss, chief dietitian at the Oakland hospital; Gay M. Deobald, chief dietitian at the Vallejo hospital; Edith L. Strock and Doris R. Barron, chief dietitian and assistant dietitian, respectively, at the San Francisco hospital, and Ann Drinkwalter, chief dietitian, South San Francisco hospital.



...*when* can I take my baby off formula?

Most doctors feel it is wisest to continue the infant's evaporated milk formula for six months, adjusting it from time to time to meet his changing needs. Evaporated milk processing makes it easier to digest than fresh milk. This is important, since digestive upsets and diarrheas are both more difficult to treat and potentially more serious during infancy.

During baby's important first six months, you can count on the *known digestibility* of his individual evaporated milk formula to give him basic growth protection. It is far wiser to give baby this protection than to try to turn him into an adult too early!

Carnation

"FROM CONTENTED COWS"

Optimum prescription-quality in today's trend to the individual formula.

and tray trucks with hot and cold sections was the most satisfactory for our operation.

The use of tray trucks, with one heated section for hot plates and two cold sections for the completely assembled cold trays, prompted us to explore a more satisfactory system whereby all the hot plates would be prepared in one central preparation area. The foods would be partially cooked, portioned on plates and then frozen. These frozen meals would be shipped to each hospital and then reconstituted as needed at each location.

PRELIMINARY TESTS

This experiment was carried out at one of our hospitals. Under contract with an outside food service concern, the food for all patients was prepared at the hospital and assembled on aluminum foil trays, comparable to those used for TV frozen dinners. These meals were frozen and stored at the hospital. The dietitian selected what was required for each meal from this supply. The meals were reconstituted with conventional heat in standard ovens and/or steam pressure cookers, and delivered to the patients in the tray trucks. Because the over-all appearance of the food left much to be desired, we began to pursue other ways to improve our food service.

We next investigated microwave ovens. With these ovens, cooking is done with microwave energy. As the microwaves penetrate, they produce heat instantaneously on the surface and inside the food. If raw food could be assembled on a plate, seasoned as desired, and cooked on the plate in the microwave oven, it would dispense with the bulk precooking, freezing and storage required in producing precooked, frozen meals. Standard china plates could be used and the raw food assembled on the plates in each floor serving kitchen. Initial tests using microwave ovens indicated that such a system might be developed.

We then purchased a two-magnetron microwave oven to determine its potential under actual operating conditions. These tests indicated that:

1. A covering over the plate is required to prevent dehydration of the food items after they are assembled on the plate. A transparent wrapping that adheres to the underside of the plate was used.

2. Food flavors are not transferred from one item to another on the plate.

3. A degree of pre-preparation is desirable on meats, potatoes and certain vegetables. We found that meats, fish, poultry and browned potatoes did not receive the customary browning. Boiled and baked potatoes, fresh vegetables, frozen Lima beans and asparagus and a few other items require a longer cooking time than is desirable for other items on the plate.

All of these factors were taken into consideration when we set up full-scale food service operation with microwave ovens at Kaiser Foundation Hospital in Walnut Creek, Calif., in November of 1955. This 90-bed hospital was equipped with 2 microwave ovens at a cost of $5,950 and 5 tray trucks at a cost of $3,450. Another $200 was required to build a plate assembly table and to relocate existing equipment.

The same basic system, using 4 microwave ovens, has been in operation since September 1956 at our 210-bed hospital in San Francisco. Initial plans have been completed for installing the same system in our remaining hospitals in Northern California, at Oakland, Vallejo and South San Francisco.

Our newly-constructed 60-bed Harbor City hospital in the Los Angeles area is equipped for this type of service. The two-oven operation went into effect this month. The dietitians at each of these locations have provided professional consultation in helping to work out this type of service, even though we have not installed the system at each location.

NEW SYSTEM INSTALLED

In setting up this system of food service, the following production and service procedures were established:

1. Pre-preparation of foods. This operation is spread over the entire eight-hour work day, and is scheduled so that the food is prepared several days in advance of use. After the food is cooked to the prescribed degree of doneness, it is frozen or refrigerated, depending upon when it will be used.

It was decided that eventually pre-preparation, including salads and desserts, would be accomplished through outside suppliers or at our own preparation center.

2. Assembly of food on plates and in cups. Cold food is assembled on the plates in accordance with the diets specified on the diet cards. The transparent covering is placed over the plate and the plates are stored on shelves adjacent to the microwave ovens. They remain on the shelves for approximately 30 minutes before being processed through the microwave ovens. Canned soup is dished up cold in bouillon cups and placed on trays and stored adjacent to the ovens.

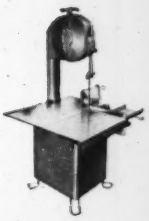
3. Tray assembly. After all the cold items and silverware have been assembled on the trays, the trays are placed in the two cold compartments of the truck. These loaded trucks are stored adjacent to the microwave ovens.

4. Heating the plates. The plates and cups of soup are processed through the microwave oven and placed in the heated section of the truck to correspond to the order in which the trays were placed in the cold section of the truck. The cup of soup is covered with a stainless steel lid after it is reconstituted. With this system, the room and bed number can be marked on the transparent covering with a felt-tip, marking pen, if desired.

The plates and the cups of soup are placed in the oven cavity at the same time. The automatic timer is set for the prescribed number of seconds (between 40-50 seconds for a regular diet of meat, vegetable and potato); the oven door is closed, and starter button pressed. When the cycle is completed, the oven automatically turns off and the plate and cup of soup are removed and placed in the heated section of the truck.

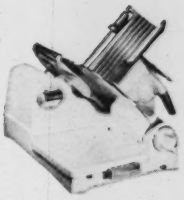
All food items are reconstituted to a temperature of approximately 180°F. Although more than one plate can be heated at once, our time and motion studies indicate it is just as fast or faster to do one plate at a time in the oven. It takes approximately 40 minutes each meal period to process all the patient plates through the 2 microwave ovens at our Walnut Creek hospital.

Food for the employees' cafeteria



HI-SPEED SAW

Has extra large working area, big capacity to speed production. Clean operation, maximum cleaning ease. Choice of models with 16" or 12" wheels.

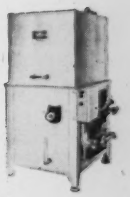


SLICER

Safe, efficient, convenient. Has illuminated platter. Tops for slicing meat, cucumbers, tomatoes and other foods.

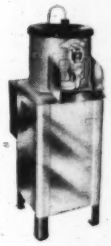
DISPOSER

Shreds all food wastes and flushes them down drain. Truly sanitary, efficient. ½ HP sizes for dish-scraping. 3 and 5 HP for food preparation areas.



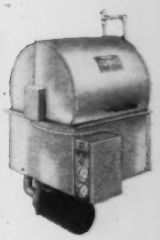
DOOR-TYPE DISHWASHER

Efficient three-way door. Choice of timed automatic or push-button controls. Fast, thorough, dependable.



PEELER

Sharp abrasive on *both* disc and cylinder for complete peeling with minimum waste. Full choice of sizes from 15 lb. (Portable Bench Type) to 70 lb. capacity.

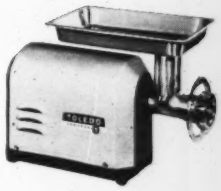


COUNTER DISHWASHER

Compact, fits in minimum space. Automatic through entire wash, drip-down and rinse cycle. (Model CA-20). Also push-button operated models.

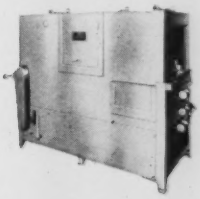
CHOPPER

Choice of 1/3 HP to 7½ HP and up to 25 HP models. Trouble-free, smartly modern in appearance. Easy to clean and keep sparkling clean.



CONVEYOR DISHWASHER

Wide choice of models, either single or double-tank types. Capacity to 12,600 dishes hourly. Integral pre-wash available.



Here's your recipe for modern cost control . . . new TOLEDOS in your kitchen!

Streamline your food service and pare your kitchen costs. Go modern with new Toledos! There are plenty of good reasons for choosing Toledo—whatever the job to be done in your kitchen. In the wide choice of meat processing machines, peelers, disposers, and dishwashers, you'll find just the right equipment you need for speedy, dependable performance and all-important ease of cleaning.

Let us show you how Toledos can step up efficiency in your kitchen . . . lighten the work-load and save you money. Write today for Bulletin SD-3815.

TODAY, IT PAYS MORE THAN EVER TO GO **TOLEDO®** ALL THE WAY!

TOLEDO SCALE COMPANY, KITCHEN MACHINE DIVISION, 245 HOLLENBECK ST., ROCHESTER, N.Y.

is reconstituted in the microwave ovens in bulk. The meat is placed in large, glass, serving dishes, reconstituted, and placed directly on the serving counter.

5. Delivery of trays to patient. The transparent covering is left on the hot plate until it is delivered to the patient to allow a minimum of heat loss. The covering is taken off the plate by the nurse or the patient, in accordance with the patient's wishes. Most patients prefer to take it off themselves, because it keeps the food hot until they are ready to eat.

EVALUATION OF SYSTEM

Patient reaction to this type of food service has been very good. They have expressed their appreciation in receiving hot, tasty food. The color and texture of food on the hot plates has been very satisfactory.

By using microwave ovens we have been able to achieve a much better yield from meat items. There is less shrinkage and less waste when we machine-slice all roasts in the cold state. We have been able to effect excellent portion control and to keep waste to a minimum.

Since putting this system into operation, we have realized a saving in raw food cost of 3.3 cents per meal served and a saving in total food costs (labor and raw food) of approximately 8 cents per meal served. Currently our raw food costs average 30-31 cents per meal.

At the present time this system has resulted in a 15 per cent reduction in the total dietary staff at the Walnut Creek hospital. However, it is anticipated that a reduction of approximately 30 per cent will be realized when the production center is placed in operation and further rearrangement of equipment is completed.

We feel that this system of food service offers an even greater potential for improving food service to patients in Kaiser Foundation Hospitals. It is our belief that many more refinements, improvements and economies will be realized as more and more experience is gained with this system. ■

Notes and Comment

Dietitian shares her recipes

Recipes for two popular Southern dishes—hush puppies and tamale pie—and a country-wide favorite food—Hungarian goulash—are presented below through the courtesy of Ann Hains of Harlan (Ky.) Memorial Hospital. Miss Hains is director of nutrition and dietary services, Harlan area, Miners Memorial Hospital Association. Miss Hains has included tamale pie as a Sunday night entree on her first-week spring cycle menu, page 82.

The recipes which each yield 50 servings are as follows:

HUSH PUPPIES (KENTUCKY)
(50 servings)

3 c. corn meal
1 c. flour
1 tsp. salt
2 tbsp. baking powder
1 egg
1 tbsp. sugar
1 small onion, grated

1. Mix ingredients with boiling water.

2. Fry in hot deep fat, dropping 1 tablespoon of mixture into fat at a time.

TAMALE PIE
(50, 6 oz. portions)

1 lb. 9 oz. (1¼ qts.) white corn meal
1¼ qts. cold water
1½ oz. (2⅔ tbsp.) salt
1 gal. boiling water
1 lb. (2⅔ c.) finely chopped onion
12 oz. (2½ c.) finely chopped green pepper
5 lbs. 8 oz. ground beef
5 oz. (⅔ c.) margarine
2½ qts. canned tomatoes
1 lb. 6 oz. (1¼ qts.) sliced ripe olives (optional)
1 oz. (2 tbsp.) salt
2¼ oz. (½ c.) chili powder

1. Mix corn meal with cold water and stir into boiling, salted water. Cover and cook over boiling water for 40 minutes.

2. Sauté onion, green pepper and ground beef in margarine until onion is tender and meat is browned.

3. Add tomatoes, olives, salt and chili powder. Cook until thick, approximately 15 minutes.

4. Stir half the corn meal mush (2½ qts. or 5 lbs. 8 oz.) into the meat mixture.

5. Pour into greased baking pans.

6. Use a No. 30 scoop to top each portion with remaining mush. Brush with melted butter or margarine.

7. Bake at 375°F. (moderate oven) for 20 minutes.

HUNGARIAN GOULASH
(50, 7 oz. portions)

13 lbs. beef, cubed
4 oz. (½ c.) shortening
1 lb. onions, quartered
1 oz. paprika
Meat stock to cover
1 green pepper, chopped
1 c. celery, diced 1 inch
3 c. tomatoes, whole
8 oz. carrots, quartered
Salt as needed
Pepper as needed
6 oz. (¾ c.) flour
4 lbs. potatoes, quartered

1. Brown cubed beef in half of shortening.

2. Sauté onions in remaining shortening. Sprinkle paprika on onions.

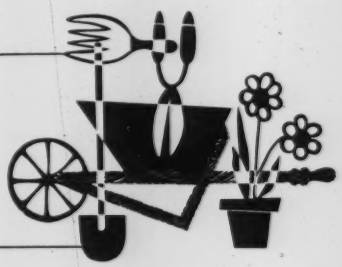
3. Add onions to meat and cover with stock. Cook 1 hour.

4. Stir in remaining vegetables and seasonings.

5. Blend flour paste into stew.

6. Add potatoes 30 minutes before meat is done. ■

Spring Cycle Menu for the South-Southwest



THE 21-DAY selective spring cycle menu and market orders for perishables on pages 82-85 are designed for hospitals in the South and Southwest. These menus, which are to be used during March, April and May, feature foods popular in the South, including many pies, and hot breads on each breakfast and noon menu.

The menus in this issue are the second in a four-part series of spring cycle menus published in this Journal. Spring cycle menus for Midwest hospitals were included on pages 69, 70 and 72 of the January 1 HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. The spring menus for hospitals in the East and North-Northwest will be published in the February 1 and 16 issues, respectively.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. Moreover, a moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

Hospitals using the AHA Master Menu service are asked to use the January and February 1956 menus, published in the December 1955 and January 1 and 16, 1956 issues of this Journal, until the spring cycle menus go into effect March 1.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other preprepared items.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

This list of supplies was published on page 73 of the January 1 issue of this Journal. The standard is also available upon request from the Association, 18 E. Division St., Chicago 10.

1st WEEK SOUTH-SOUTHWEST SELECTIVE SPRING CYCLE MENU—prepared by Ann Hains, director, nutrition and dietary services, Harlan area, Miners Memorial Hospital Association, Harlan, Ky.

	breakfast	noon	night
monday	Grapefruit Juice **or** Stewed Rhubarb Oatmeal **or** Ready-to-Eat Rice Cereal Scrambled Egg Bacon Muffin	Consomme Roast Leg of Veal—Gravy (FS) **or** Corned Beef Hash with Sliced Hard-Cooked Egg Whipped Potatoes (FS) **and** Parker House Roll Seasoned Green Beans (FS) **or** Creamed Onions Spring Salad—Oil and Vinegar Dressing **or** Arabian Peach Mold Iced Chocolate Brownie (F) **or** Bananas Sliced in Pineapple Juice (S)	Fruit Punch Braised Beef Cube Steak au jus (FS) **or** Baked Sausage Pattie on Pineapple Slice Buttered Diced Potatoes (FS) Baked Acorn Squash (FS) **or** Buttered Broccoli Head Lettuce—Bleu Cheese Dressing **or** Waldorf Salad Bavarian Cream—Orange Sauce (FS) **or** Prune Plums in Syrup
tuesday	Apple Juice **or** Sliced Orange Farina **or** Bran Flake Cereal Bacon Nut Muffin	Navy Bean Soup Beef and Vegetable Stew with Potatoes (F) **or** Oven-Broiled Liver—Gravy (S) Boiled Potatoes in Jackets (S) **and** Biscuits Buttered Cut Cabbage **or** Buttered Sliced Beets (S) Grapefruit Sections-Pimiento Strip—French Dressing **or** Cucumbers Marinated in Salad Dressing Blackberry Cobbler (F) **or** Vanilla Ice Cream	Cranberry Juice Cocktail Baked Pork Chop—Over Dressing (F) **or** Creamed Turkey on Rusk (S) Glazed Sweet Potatoes (F) Buttered Peas (FS) **or** Stewed Tomatoes and Okra Celery Stuffed with Peanut Butter **or** Molded Cinnamon Applesauce Butterscotch Pudding (FS) **or** Maraschino Cherry Cake
wednesday	Apricot Nectar **or** Half Grapefruit Grits **or** Puffed Rice Cereal Soft Cooked Egg Plain Muffin-Jelly	Turkey Alphabet Soup Roast Boneless Lamb Shoulder—Cranberry Jelly (FS) **or** Crab Cakes—Cocktail Sauce Oven Hash Brown Potatoes **and** Cornbread Buttered Carrot Sticks (FS) **or** Seasoned Collards Shredded Lettuce—Bacon Dressing **or** Pineapple Slice—Prune Garnish—Mayonnaise Cream Puff **or** Pears in Syrup (FS)	Loganberry Punch Ham and Cheese Roll (F) **or** Oven-Broiled Chicken (quarter) (S) Buttered Rice (FS) Buttered Yellow Squash (FS) **or** Cauliflower Polonaise Sliced Tomato Salad—French Dressing **or** Mixed Fruit Salad—Whipped Cream Dressing Lemon Delicacy (FS) **or** Fresh Fruit in Season
thursday	Orange Juice **or** Stewed Prunes Whole Wheat Cereal **or** Corn Flakes Link Sausages Biscuits-Syrup	Oxtail Soup Pot Roast of Beef—Gravy (FS) **or** Bacon-Wrapped Frankfurter Baked Potato **and** Cloverleaf Roll Whole Kernel Corn (F) **or** Buttered Green Beans (S) Tossed Green Salad—Russian Dressing **or** Apricot Halves—Cream Cheese Center Glorified Bread Pudding (FS) **or** Bunch of Grapes	Lemonade Breaded Veal Cutlet—Tomato Sauce (F) **or** Broiled Beef Pattie (S) Escalloped Potatoes Seasoned Spinach (FS) **or** Boiled Onions Perfection Salad **or** Banana-Toasted Coconut Salad Red Cherry Pie (F) **or** Orange Sherbet (S)
friday	Orange Juice **or** Kadota Figs Oatmeal **or** Corn Soybean Cereal Poached Egg Red Cherry Muffin	Limeade Baked Red Perch Fillet-Lemon Butter (FS) **or** Barbecued Spareribs Parsley Buttered Potato Corn Sticks Buttered Peas (FS) **or** Buttered Celery Old Fashioned Cole Slaw **or** Sliced Orange Salad—French Dressing Applesauce Spice Stack Cake (FS) **or** Strawberry Ice Cream	Clam Chowder Meat Loaf—Gravy (F) **or** Baked Cheese Sandwich (S) Whipped Potato (F) Harvard Beets (FS) **or** Buttered Patty Pan Squash Head Lettuce—1000 Island Dressing **or** Peach Half Salad—Raisins in Mayonnaise Center Prune Whip (FS) **or** Chocolate Meringue Pie
saturday	Orange Juice **or** Sliced Banana Farina **or** Ready-to-Eat Malt Flake Cereal Griddle Cakes —Syrup	Cream of Celery Soup Diced Beef and Noodle Casserole (FS) **or** City Chicken Browned Whole Potato **and** Sally Lunn Muffin Buttered Ford Hook Lima Beans (F) **or** Buttered Cut Asparagus (S) Celery Hearts, Pickle Chips **or** Grape Waldorf Salad Nectarines in Syrup (FS) **or** Red Raspberry Chiffon Pie—Graham Cracker Crust	Tomato Juice Roast Leg of Lamb—Gravy (FS) **or** Scalloped Ham and Potatoes Buttered Brown Rice (FS) Parslied Carrot Circles (FS) **or** Buttered Brussel Sprouts Chef Salad—Chef Dressing **or** Pear Half Salad—Mint Jelly Lazy Daisy Cake (F) **or** Lime Sherbet (S)
sunday	Orange Juice **or** Applesauce Grits **or** Ready-to-Eat Wheat Flake Cereal Scrambled Egg Sweet Roll	Grape Punch Roast Turkey—Gravy (FS)—Cornbread Dressing **or** Swiss Steak Whipped Potatoes Biscuits Scalloped Apples (FS) **or** Seven-Minute Cabbage Molded Bing Cherry Salad **or** Carrot and Peanut Salad Chocolate Sundae (FS) **or** Pecan Pie	Potato Soup Open-Faced Hot Beef Sandwich—Gravy (FS) **or** Tamale Pie Seasoned Green Beans (FS) **or** Buttered Turnips Pickled Beets and Onion Rings **or** Pineapple, Royal Anne Cherry and Marshmallow Salad—Mayonnaise Orange Chiffon Cake (FS) **or** Apricots in Syrup

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Chuck-Eye Roll	U. S. Good	30 lbs.	90
Bottom Butts (B.R.T.)	U. S. Good	40 lbs.	120
Corned, Rump	U. S. Commercial	10 lbs.	50
Frankfurters	8-1#	5 lbs.	20
Liver, Sliced	Steer	5 lbs.	25
Ground	U. S. Commercial, 5 lb. pkg.	25 lbs.	100
Steak, Swiss	U. S. Good, 4 oz. ea.	10 lbs.	40
Steak, Cubed	U. S. Choice, 4 oz. ea.	30 lbs.	120
Stew	U. S. Good	25 lbs.	125
LAMB			
Shoulder (Boneless, B.R.T.)	U. S. Good	40 lbs.	120
Leg (B.R.T.)	U. S. Good	30 lbs.	90
PORK			
Sausage Links	12-1#	10 lbs.	50
Spareribs	3-1# or less	20 lbs.	40
Bacon (Sliced)	24-26—1#	6 lbs.	72
Sausage (Bulk)	Lean	5 lbs.	20
Chops, Loin (Bone In)	Grade A, 5 oz. each	30 lbs.	90
Ham (Pullman)		10 lbs.	40

Item, Specifications, Amounts & No. of Servings			
VEAL			
Leg (B.R.T.)	U. S. Good	30 lbs.	90
Cutlets	U. S. Good, 4 oz. each	20 lbs.	80
FISH			
Perch	Ocean fillets	20 lbs.	80
POULTRY			
Fryers (Eviscerated)	Grade A, 2½ lb. av.	30 lbs.	40
Turkey, Tom (Eviscerated)	Grade A, 20 lb. av.	60 lbs.	100
FRESH FRUITS			
Apples	Jonathan, 113s	2 boxes	226
Bananas	Ripe	60 lbs.	180
Grapefruit	Seedless, 70s	1 box	140
Grapes	Emperor	1 box	100
Lemons		1 doz.	
Oranges	176s	1 box	176
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	200
Carrots	Topped, bag	100 lbs.	350
Celery	Pascal, 30s	1 crate	150
Cucumbers		1 doz.	
Lettuce	Head, 48s	2 crates	
Onions, Dry	50 lb. bag	1 bag	

Item, Specifications, Amounts & No. of Servings			
Onions, Green	Bunch	1 doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag, #1	300 lbs.	
Radishes	Bunch	1 doz.	
Squash, Acorn		20 lbs.	
Tomatoes	Repacked (5x6)	1 lug, 30 lbs.	
Turnips, White	Topped	10 lbs.	40
FROZEN FRUITS			
Orange Juice	Con., 32 oz. can	12 cans	384
Raspberries	5-1 sugar	8½ lb. pkg.	
Rhubarb	1 lb. pkg.	5 lbs.	25
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	5 lbs.	15
Beans, Green	Cut, 2½ lb. pkg.	40 lbs.	200
Beans, Lima	2½ lb. pkg.	15 lbs.	90
Broccoli	2½ lb. pkg.	5 lbs.	30
Brussel Sprouts	2½ lb. pkg.	5 lbs.	12
Cauliflower	2½ lb. pkg.	10 lbs.	60
Collards	2½ lb. pkg.	10 lbs.	60
Peas	2½ lb. pkg.	40 lbs.	200
Spinach	2½ lb. pkg.	15 lbs.	90
Squash	1 lb. pkg.	8 lbs.	32
Squash, Patty Pan	1 lb. pkg.	4 lbs.	24

PLEASE CUT OUT ALONG THIS LINE

FAMED FOR FINE FOOD FOR 74 YEARS

Sexton Quality Foods

Across the country, you see the distinctive trucks of the far-famed Sexton great white fleet supplying more than 60,000 establishments from restaurants to hospitals, from schools to railway dining cars. Sexton service is keyed to the particular needs of those who feed many people each day and all the various Sexton products are delivered direct to the storeroom of each Sexton customer. At all times, there is a helpful Sexton salesman in your community—trained to the special requirements of the institutional market. Fully stocked nation-wide Sexton branch warehouses insure immediate service.

JOHN SEXTON & CO.
CHICAGO
LONG ISLAND CITY
SAN FRANCISCO
PHILADELPHIA
BOSTON
PITTSBURGH
DALLAS
ATLANTA
DETROIT
INDIANAPOLIS

2nd WEEK SOUTH-SOUTHWEST SELECTIVE SPRING CYCLE MENU—prepared by Ann Hains, director, nutrition and dietary services, Harlan area, Miners Memorial Hospital Association, Harlan, Ky.

	breakfast	noon	night
monday	Blended Orange and Grapefruit Juice **or** Stewed Dry Apricots Whole Wheat Cereal **or** Puffed Wheat Cereal Poached Egg Blueberry Muffin	Cream of Turkey Soup Boneless Pork Loin Roast—Gravy (F) **or** Oven-Broiled Veal Pattie (S) Mashed Sweet Potatoes (FS) Parker House Roll Cream Style Corn (F) **or** Buttered Spinach (S) Head Lettuce—Chiffonade Dressing **or** Citrus Salad—French Dressing Red Gelatin Cubes in Whipped Cream (FS) **or** Snoflake Pie	Pineapple Juice Spaghetti with Meat Sauce (F) **or** Boiled Chicken—Fricassee Gravy (S) Buttered Potatoes (S) Buttered Peas (S) **or** Fried Eggplant Garden Salad—Oil and Vinegar Dressing **or** Cottage Cheese—Peach Slice Garnish Elberta Peaches in Syrup (FS) **or** Boston Cream Pie
tuesday	Orange Juice **or** Bunch of Grapes Oatmeal **or** Ready-to-Eat Rice Cereal Bacon Grapenut Muffin	Chicken Noodle Soup Roast Beef—Gravy (FS) **or** Creole Shrimp Steamed Rice (FS) Cornbread Buttered Diced Beets (FS) **or** Buttered Cauliflower Vegetable Sticks **or** Blushing Pear Salad—Endive Dutch Apple Pie (F) **or** Royal Anne Cherries in Syrup (S)	Gingerale Punch Meat and Cabbage Rolls—Lemon (F) **or** Scrambled Eggs and Mushrooms (S) Baked Potato (FS) Baked Acorn Squash (FS) **or** Seasoned Mixed Greens Jellied Cucumber Salad **or** Banana Rolled in Chopped Nuts Vanilla Ice Cream (FS) **or** Whole Orange
wednesday	Orange Juice **or** Stewed Prunes Farina **or** Shredded Wheat Cereal Fried Corn Meal Mush—Syrup	Split Pea Soup Creamed Chipped Beef on Chinese Noodles (F) **or** Braised Beef Cubes—Brown Sauce (S) Whipped Potatoes (S) **and** Biscuits Buttered Julienne Carrots (FS) **or** Escalloped Tomatoes Mixed Green Salad—French Dressing **or** Hawaiian Waldorf Salad Chocolate Marshmallow Pudding (FS) **or** Lime Sherbet	Blackberry Punch Roast Leg of Veal—Currant Jelly (FS) **or** Grilled Country Ham Creamed Potatoes (FS) Seasoned Green Beans (FS) **or** Mashed Turnips Tomato Wedge Salad—Mayonnaise **or** Apricot Salad—Red Cherry Garnish Gingerbread—Hard Sauce (FS) **or** Half Grapefruit
thursday	Orange Juice **or** Stewed Rhubarb Grits **or** Bran Flake Cereal Soft Cooked Egg Quick Coffee Cake	Bouillon Breaded Baked Pork Chop—Cream Gravy (F) **or** Braised Lamb Shoulder Chop (S) Paprika Buttered Potatoes (FS) **and** Corn Sticks Buttered Spinach (FS) **or** Boiled Dry Pinto Beans Marinated Cauliflower and Pimiento **or** Prunes Stuffed with Cream Cheese Bing Cherries in Syrup (S) **or** Jam Cake (F)	Pink Lemonade Oven-Broiled Chicken (FS) **or** Escalloped Apples and Link Sausages Baked Yams (FS) Buttered Cut Asparagus (FS) **or** Savory Onions Gingerale Fruit Salad **or** Head Lettuce—Paprika Mayonnaise Strawberry Ice Cream **or** Banana Pudding (FS)
friday	Prune Juice **or** Half Grapefruit Oatmeal **or** Corn Soybean Cereal Sausage Cake Apple Muffin	Cream of Mushroom Soup Braised Cube Steak in Gravy (FS) **or** Salmon Loaf—Parsley Sauce Oven Lyonnaise Potatoes (FS) **or** Cloverleaf Roll Buttered Peas (FS) **or** Buttered Broccoli Tossed Green Salad—French Dressing **or** Pineapple Slice—Grated American Cheese Lemon Meringue Pie (F) **or** Pear Half in Syrup (S)	Grape-Apple Punch Baked Halibut—Lime Wedge (FS) **or** Meat-Biscuit Roll—Gravy Baked Potato (FS) Harvard Beets (FS) **or** Seven-Minute Cabbage Carrot and Raisin Salad **or** Grapefruit Section-Green Pepper Strip—French Dressing Pink Iced Angel Food Cake (FS) **or** Green Gage Plums in Syrup
saturday	Apricot Nectar **or** Sliced Orange Corn Meal Mush **or** Puffed Rice Cereal Poached Egg Prune Muffin	Vegetable Soup Hamburger in a Bun—Pickle Relish (F) **or** Braised Veal Cutlet (S) Whipped Potatoes (S) Mashed Hubbard Squash (S) **or** Baked Whole Tomato (F) Mexican Cole Slaw **or** Pear Half—Dates and Nuts in Mayonnaise Apricots in Syrup (FS) **or** Peanut Butter Pie	Hawaiian Punch Baked Liver—Brown Sauce (FS) **or** Corn Fritters—Syrup—Bacon Curls Buttered Diced Potatoes (FS) Buttered Carrots (FS) **or** Seasoned Turnip Greens Spring Salad—French Dressing **or** Spiced Peach on Endive Creamy Rice Pudding (FS) **or** Raw Apple
sunday	Orange Juice **or** Sliced Banana Farina **or** Corn Flakes Bacon Date Roll	Chicken-Ripple Soup Baked Ham—Cinnamon Apple Ring (F) **or** Roast Leg of Lamb—Gravy (S) Glazed Sweet Potatoes (FS) Corn Muffin Seasoned Green Beans (FS) **or** Buttered Brussel Sprouts Molded Cranberry Sauce Salad **or** Head Lettuce—1000 Island Dressing English Toffee Cake (FS) **or** Fresh Fruit in Season	Red Cherry Orangeade Pot Roast of Beef—Gravy (FS) **or** Chili Con Carne—Crackers Parsley Buttered Potatoes (FS) Buttered Mixed Vegetables (F) **or** Buttered Asparagus (S) Celery Stuffed with Cheddar Cheese Spread **or** Ambrosia Salad (Sliced Orange and Coconut) Vanilla Ice Cream (FS) **or** Old Fashioned Fruit Bar

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Round, Top (Boneless)	U. S. Good	30 lbs.	90
Ground	U. S. Good, 5 lb. pkg.	100 lbs.	400
Liver, Sliced	Steer	15 lbs.	75
Chipped Beef (Dry)		5 lbs.	50
Stew	U. S. Choice	15 lbs.	60
Steak, Cubed	U. S. Choice, 4 oz. each	30 lbs.	120
Sirloin Butt (Bottom, B.R.T.)	U. S. Good	30 lbs.	90
LAMB			
Chops, Shoulder	U. S. Choice, 5 oz. each	10 lbs.	30
Leg (B.R.T.)	U. S. Choice, Yearling	5 lbs.	15
PORK			
Bacon (Sliced)	24-26-1#	24 lbs.	288
Pork Loin (Boneless)	Grade A, 10#-12#	30 lbs.	90
Pork Chop, Loin	Grade A, 4 oz. each	25 lbs.	100
Ham (Pullman)	10 lb. av.	40 lbs.	120
Sausage Links	12-1#	5 lbs.	20
Sausage (Bulk)		25 lbs.	75

Item, Specifications, Amounts & No. of Servings			
VEAL			
Shoulder (Boneless)	U. S. Good	10 lbs.	40
Leg (B.R.T.)	U. S. Good	30 lbs.	90
Cutlet	U. S. Good, 4 oz. each	5 lbs.	20
FISH			
Shrimp, Green	26-30—1#	5 lbs.	20
Halibut Steaks	5 oz. each	25 lbs.	75
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	10 lbs.	40
Fryers (Eviscerated)	Grade A, 2 lb. av.	40 lbs.	80
FRESH FRUITS			
Apples	Jonathan, 113s	2 boxes	226
Bananas	Ripe	45 lbs.	135
Grapefruit	Seedless, 70s	3 boxes	320
Grapes	Emperor, 28 lb. box	1 box	100
Orange	176s	3 boxes	528
FRESH VEGETABLES			
Cabbage	Bag	100 lbs.	400
Carrots	Topped, bag	100 lbs.	350
Celery	Pascal, 30s	1 crate	
Cucumbers		1 doz.	

Item, Specifications, Amounts & No. of Servings			
Egg Plant		10 lbs.	80
Lettuce	Head, 48s	3 crates	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	
Potatoes, Sweet	Hamper	100 lbs.	
Potatoes, White	Bag, #1	300 lbs.	
Radishes	Bunch	1 doz.	
Squash, Acorn		10 lbs.	50
Squash, Hubbard		10 lbs.	50
Tomatoes	Repacked (5x6)	3 lugs, 90 lbs.	
Turnips, Yellow		5 lbs.	25
FROZEN FRUITS			
Orange Juice	Con., 32 oz. can	12 cans	384
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	17½ lbs.	105
Beans, Green	2½ lb. pkg.	30 lbs.	180
Broccoli	2½ lb. pkg.	2½ lbs.	15
Brussel Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	2½ lb. pkg.	15 lbs.	90
Greens, Mixed	2½ lb. pkg.	5 lbs.	30
Peas	2½ lb. pkg.	30 lbs.	180
Spinach, Chopped	2½ lb. pkg.	30 lbs.	180
Turnip Greens	2½ lb. pkg.	5 lbs.	45

PLEASE CUT OUT ALONG THIS LINE

3rd WEEK SOUTH-SOUTHWEST SELECTIVE SPRING CYCLE MENU — prepared by Ann Hains, director, nutrition and dietary services, Harlan area, Miners Memorial Hospital Association, Harlan, Ky.

	breakfast	noon	night
monday	Orange Juice **or** Kadota Figs Oatmeal **or** Ready-to-Eat Malt Flake Cereal Scrambled Egg Jelly Muffin	Scotch Broth Baked Haddock—Lemon Butter (S) **or** Boiled Smoked Cottage Butt (F) Au Gratin Potatoes (FS) Biscuits Buttered Broccoli **or** Seasoned Spinach (FS) Tomato Salad—French Dressing **or** Mixed Fruit Salad—Mayonnaise Apple Crisp (FS) **or** Assorted Gelatin Cubes	Boysenberry Punch Porcupine Meat Balls-Tomato Sauce (FS) **or** Broiled Veal Chop Whipped Potatoes (FS) Buttered Peas (FS) **or** Parslied Cauliflower Tossed Green Salad—Lorenzo Dressing **or** Cottage Cheese-Lime Salad Orange Kiss Me Cake (F) **or** Pineapple Sherbet (S)
tuesday	Orange Juice **or** Prune Plums in Syrup Whole Wheat Cereal **or** Ready-to-Eat Wheat Flake Cereal Link Sausage Pineapple Muffin	Tomato Okra Soup Roast Leg of Veal—Gravy (FS) Bread Dressing (F) **or** Deviled Pork Chop Buttered Diced Potatoes (FS) Parker House Roll Buttered Sliced Beets (FS) **or** Creole Celery Lettuce Wedge—Roquefort Cheese Dressing **or** Apple-Raisin Salad—Salad Dressing Cottage Pudding—Chocolate Sauce (FS) **or** Whole Banana	Red Cherry Punch Chicken-Noodle Casserole (FS) **or** Corned Beef Boiled Potato Seven-Minute Cabbage **or** Baked Acorn Squash (FS) Cucumber and Onion Ring Salad **or** Pear Half—Prune Garnish Chocolate Ice Cream (FS) **or** Blueberry Cobbler
wednesday	Orange Juice **or** Stewed Dried Apricots Farina **or** Shredded Wheat Cereal Soft Cooked Egg Caramel Roll	Julienne Vegetable Soup Roast Beef—Gravy (FS) **or** Frankfurter in a Bun Creamed Potato (FS) Buttered Carrot Circles (FS) **or** Seasoned Kale Pea, Pickle, Peanut Salad **or** Molded Diced Peach Salad Royal Anne Cherries (FS) **or** Sweet Potato Pie	Limeade Ham and Eggs in Cheese Sauce on Cornbread (F) **or** Braised Lamb Shoulder Chop (S) Whipped Potatoes (S) Seasoned Green Beans (FS) **or** Buttered Mixed Vegetables Chef Salad-Chef Dressing **or** Pineapple, Banana, Marshmallow Salad Jelly Roll (FS) **or** Lime Sherbet
thrusday	Orange Juice **or** Applesauce Oatmeal **or** Puffed Rice Cereal French Toast—Syrup	Corn Chowder Roast Turkey—Gravy (FS) **or** Meat Croquettes Buttered Rice (FS) Cloverleaf Roll Buttered Baby Limas (F) **or** Buttered Yellow Squash (S Vitamin Salad **or** Molded Grapefruit Salad Raisin Lattice Pie (F) **or** Baked Custard (S)	Cranberry-Apple Punch Baked Round Steak, Brown Sauce (FS) **or** Breaded Pork Tenderloin—Cream Gravy Whipped Potatoes (FS) Stewed Tomatoes (F) **or** Buttered Peas (S) Shredded Lettuce—Oil and Vinegar Dressing **or** Orange Section Salad—Green Pepper—French Dressing Peach Half in Syrup (FS) **or** Maple Nut Pudding
friday	Pineapple Juice **or** Sliced Orange Grits **or** Corn Flakes Bacon Cinnamon Raisin Toast	Tomato Soup Tuna-Macaroni Casserole (FS) **or** Ham Loaf—Mustard Sauce Glazed Sweet Potatoes Corn Muffin Seasoned Spinach (FS) **or** Buttered Cut Cabbage Golden Glow Salad **or** Apple Slices—Date Center—Mayonnaise Butterscotch Sundae (FS) **or** Banana Fiesta Cake	Orangeade Braised Veal Cube Steak Au Jus (FS) **or** Baked Red Snapper—Lemon Baked Potato (FS) Harvard Beets (FS) **or** Buttered Broccoli Spring Salad—Celery Seed Dressing **or** Cottage Cheese Salad—Stuffed Olive Garnish Pears in Syrup (FS) **or** Vanilla Graham Cracker Pie
saturday	Orange Juice **or** Stewed Dried Fruit Compote Rolled Wheat Cereal **or** Puffed Wheat Cereal Poached Egg Sally Lunn Muffin	Turkey Rice Soup Roast Fresh Ham—Gravy (F) **or** Creamed Eggs on Toast (S) Oven-Browned Potato (F) Biscuits Seasoned Green Beans (FS) **or** Sauerkraut Head Lettuce—Lemon French Dressing **or** Pineapple Slice Salad—Cube Red Gelatin Center Creamy Tapioca (S) **or** Boysenberry Cobbler (F)	Vegetable Juice Cocktail Roast Beef—Gravy (FS) **or** Veal Pot Pie Whipped Potatoes (FS) Parslied Carrots (FS) **or** Stewed Tomatoes Raw Turnip Salad **or** Apricot Halves—Royal Anne Cherry Center Mint Iced Chocolate Layer Cake (FS) **or** Whole Orange
sunday	Apple Juice **or** Half Grapefruit Farina **or** Corn Soybean Cereal Bacon Jelly Sweet Roll	Beef Noodle Soup Oven-Broiled Chicken (FS) **or** Steamed Canadian Bacon Escalloped Potatoes (FS) **and** Cornbread Buttered Peas (FS) **or** Buttered Brussel Sprouts Carrot Curls, Green Pepper Sticks, Radish Rose **or** Slice of Cranberry Jelly on Lettuce Grape Pineapple Pie (F) **or** Vanilla Ice Cream, Ice Box Cookies (S)	Blended Citrus Juice Lamb Rosette (FS) **or** Braised Short Ribs of Beef Buttered Potatoes (FS) Seasoned Mixed Greens (FS) **or** Buttered Cut Asparagus Sliced Tomatoes on Endive—French Dressing **or** Cider Fruit Salad Banana Pear Peach Cup (FS) **or** Date Bars

(F)—Full Diet (S)— Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

PLEASE CUT OUT ALONG THIS LINE

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Chuck-Eye Roll (Boneless)	U. S. Good	60 lbs.	180
Corned, Brisket	U. S. Good	10 lbs.	30
Frankfurters	All beef, 8-1#	10 lbs.	40
Ground	U. S. Good, 5 lb. pkg.	20 lbs.	80
Round Steaks	U. S. Choice, 4 oz. each	20 lbs.	80
Short Ribs	U. S. Good	10 lbs.	20
LAMB			
Chops, Shoulder	U. S. Choice, 5 oz. each	5 lbs.	15
Ground	U. S. Good	25 lbs.	75
PORK			
Bacon (Sliced)	24-26-1#	12 lbs.	144
Butts (Smoked)	Lean, boneless	60 lbs.	180
Chops, Loin	Grade A, 4-1#	10 lbs.	40
Canadian Bacon	Grade A	5 lbs.	20
Ham, Fresh (B.R.T.)	Grade A	30 lbs.	90
Sausage Links	12-1#	15 lbs.	60
Tenderloin	Grade A	5 lbs.	15
VEAL			
Leg (B.R.T.)	U. S. Good	30 lbs.	90
Chops, Shoulder	U. S. Good, 5 oz. each	5 lbs.	15
Steaks, Cubed	U. S. Good, 4 oz. each	20 lbs.	80
Stew	U. S. Good	5 lbs.	20
FISH			
Haddock Fillets	Skinless	5 lbs.	20
Red Snapper Fillets		5 lbs.	20
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	20 lbs.	80
Fryers (Eviscerated)	Grade A, 2 lb. av.	50 lbs.	100
Turkey (Eviscerated)	Grade A, 20 lb. av.	60 lbs.	80
FRESH FRUITS			
Apples	Jonathan, 113s	2 boxes	226
Bananas	Ripe	30 lbs.	90
Grapefruit	Seedless, 70s	1 box	140
Lemons		1 doz.	
Oranges	176s	2 boxes	350
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	200
Carrots	Topped, Bag	100 lbs.	
Celery	Pascal, 30s	½ crate	
Cucumbers		2 doz.	
Lettuce	Head, 48s	2 crates	
Onions, Dry	50 lb. bag	1 bag	
Onions, Green	Bunch	2 doz.	
Parsley	Bunch	1 doz.	
Pepper, Green		1 doz.	
Potatoes, Sweet	Hamper	100 lbs.	
Potatoes, White	Bag, #1	300 lbs.	
Radishes	Bunch	2 doz.	
Squash, Acorn		10 lbs.	
Tomatoes	Repacked (5x6)	1 lug, 30 lbs.	
Turnips, White	Topped	10 lbs.	
FROZEN FRUITS			
Blueberries	Dry	8 lbs.	
Boysenberries	5-1 sugar, 8 lb. can	16 lbs.	
Orange Juice	Con., 32 oz. can	12 cans	384
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	15 lbs.	90
Beans, Green	Cut, 2½ lb. pkg.	30 lbs.	180
Broccoli	2½ lb. pkg.	5 lbs.	30
Brussel Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	2½ lb. pkg.	2½ lbs.	15
Greens, Mixed	2½ lb. pkg.	2½ lbs.	15
Kale	2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	30 lbs.	180
Spinach	2½ lb. pkg.	15 lbs.	90
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

the literature

hospital auditing

also:
facilities for handicapped
accrediting nursing schools

CASE STUDIES IN AUDITING; A HOSPITAL. (No. 11) American Institute of Accountants. New York, 1956. 45 pp. 50 cents.

This case study deals with the audit of a 150-bed nonprofit general hospital. The case is divided into three principal sections. In the first section, the organization of the hospital is described and illustrated by the presentation of an organization chart. The funds employed in the hospital's accounting are indicated together with illustrative financial statements for each fund.

The second section presents in some detail the organizational and accounting procedures related to the principal asset and liability items, and to operating transactions such as the receipt of cash, billing and payroll. Emphasis is placed upon the efficiency of internal control as illustrated by the separation of functions between employees and the use (and disposition) of serially numbered documents.

The third section describes the auditing procedures employed by the independent public accountant in the examination of particular asset, liability, fund balance, income and expense items.

This case study should prove valuable to the hospital administrator for several reasons. The illustrative statements provide a guide to statement organization. The rather detailed description of accounting procedures employed in the handling of significant types of transactions, such as cash receipts and disbursements, should prove helpful to the administrator in the organization or reorganization of the accounting functions in his hospital. The opportunity to become familiar with the auditing procedures employed by the independent accountant should help the administrator understand the reasons for these procedures. In addition, familiarity with basic audit procedures may make it possible for the administrator to assist the auditor by preparing various summaries and schedules in advance, thereby reducing the time required to complete the audit with a resulting saving in cost.

—SAMUEL R. HEPWORTH, *School of Business Administration, University of Michigan.*

Facilities for handicapped

DIRECTORY FOR EXCEPTIONAL CHILDREN; schools, services and other facilities. E. Nelson Hayes, editor. 2d ed. Boston, Porter Sargent, 1956. 247 pp. $2.

Although a listing of chapter headings cannot constitute a book review, such an approach seems necessary to give a true picture of the scope of this directory. Its coverage includes private boarding schools, day schools and state schools for the mentally retarded; tutoring and remedial schools; schools (both public and private) and residential treatment centers for the emotionally disturbed and socially maladjusted. Included also are boarding and day facilities for orthopedically handicapped and cerebral palsied; schools for the blind, the deaf and the speech handicapped; psychiatric and guidance clinics; speech and hearing clinics; state programs and personnel; and a listing of associations, societies and foundations concerned with the welfare of exceptional children.

Information concerning more than 1,800 facilities for the exceptional is presented. Among these facilities are hundreds of hospitals with services for the orthopedically handicapped and cerebral palsied.

The information provided is of directory type: address, telephone, administrator, control, admittance requirements, costs, etc. Arrangement of the listings is alphabetical by state and city under geographical regional groupings. The 26-page index covers the schools but not the clinics, state programs or associations.

Although there are other directories of facilities for particular handicaps, none includes such a wide range of information. Social workers, school administrators and hospital administrators would do well to have a copy for ready reference.—HELEN YAST

Accrediting nursing schools

ACCREDITING YOUR SCHOOL OF NURSING. National League for Nursing. New York, National League for Nursing, 1956. 16 pp. free, (first 5 copies, additional copies 5 cents).

This factual booklet serves two major functions, (1) it describes the purpose and principles of accreditation and (2) it explains fully the procedure of accreditation.

This booklet was written particularly for schools of nursing interested in securing accreditation. However, interest should not stop at this level. The administrator and board of trustees might also profit from the information given, since it includes the cost of surveys and fees—an item which necessarily must be considered.

High school counselors are constantly being questioned by students interested in entering nursing as to the meaning of a fully accredited school of nursing. This compact booklet should help them to answer this question.

Since the process of accreditation stresses self-evaluation, those schools already accredited might find this book a helpful guide for continuing in their status.

—M. JEANNE STICKELS, R.N., *director of nursing, St. Luke's Hospital, Kansas City, Mo.*

Washington Report

OFFICIAL NOTES

The following actions were taken by the Board of Trustees of the American Hospital Association at its meeting in Chicago Nov. 30, 1956. Further actions of the Board will be reported in the Feb. 1 issue of HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION.

BLUE CROSS ASSOCIATION

***VOTED:** To approve the following statement in regard to the reorganization of the Blue Cross Association, with the understanding that the introductory explanations by the chairman of the Council on Prepayment Plans and Hospital Reimbursement (see below) will be incorporated as a preamble to accompany distribution of the statement:*

"The American Hospital Association has studied the reorganized structure of the Blue Cross Association, as expressed in the revised bylaws accepted by the Blue Cross Plans on July 10, 1956. This reorganization was effected to provide an enrollment mechanism through which uniform Blue Cross programs could be made available to national employers. Although the reorganization of the Blue Cross Association may result in the introduction of new subscriber contracts with different hospitals service benefits and at different subscriber dues than those existing in local Plan areas, it is the opinion of the American Hospital Association that the reorganization will not of necessity adversely affect the basic relation between hospitals and Blue Cross Plans at the local level.

"The present trend toward industry-wide bargaining has created an increasing demand for nationwide uniform prepaid hospital service benefit programs. The reorganized Blue Cross Association is envisioned as the mechanism to enable Blue Cross Plans to meet this demand with minimal loss of local autonomy. Official approval of the Blue Cross Association, at the time of its original incorporation, was voted by the Board of Trustees of the American Hospital Association on Dec. 11, 1948.

"In view of the fact that the reor-

See **OFFICIAL NOTES,** *page 95*

AHA States Its Views On Prepayment For Federal Employees

The Democratic-controlled 85th Congress convened on Jan. 3.

The broad outlines of what to expect in national health legislation will be given by the President in his annual State of the Union Message. This will be followed by the annual budget message, and, in February, by a special health message. Even if President Eisenhower asks for no new health programs, Congress will have to appropriate large sums for existing programs authorized by previous Congresses.

With increased attention on defense spending, national health programs will be competing with national military needs. However, in a radio interview, prior to a final decision on the Department of Health, Education, and Welfare budget, Secretary Marion B. Folsom said: "my job is to bring to the attention of the people of the country that while we must maintain this defense posture . . . we want to be very careful that we don't let down on expenditures in the field of health, education, and welfare. It is extremely important . . . that we maintain not only a sound economy . . . but we have also to look out for our human resources."

FEDERAL EMPLOYEES' INSURANCE

A recent letter to Philip Young, chairman of the Civil Service Commission, from American Hospital Association President Albert W. Snoke set forth the Association's principles in supporting legislation to provide prepaid health services for federal employees and their dependents.

Five principles outlined in Dr. Snoke's letter were:

"First, a basic plan covering the cost of illness which requires hospitalization is by far the most important element in any health program. It follows that the government as employer should make a contribution toward the cost of such basic coverage, and should enable employees to meet the rest of that cost through payroll deductions. The federal government should contribute to the basic health protection of its employees at least to an extent comparable to the contribution to major private employers in the country.

"Second, the basic benefits should be required to be provided in an amount adequate to meet the full cost of hospital care and, so far as possible, of inhospital medical and surgical services, exclusive of the additional cost of occupying private accommodations and of private duty nursing; and should meet that cost for a stipulated number of days at least comparable to that provided in the large industrial employee health contracts. The provisions of the statute should be flexible enough to permit the inclusion of additional benefits, such as some services to ambulatory patients.

"Third, within the above framework both service plans and commercial insurance companies should be given an opportunity to participate in writing the basic benefits.

"Fourth, additional or major medical benefits, so designed as to supplement rather than duplicate the basic coverage outlined above, should also be made available to those federal employees who desire them. With respect to hospitalized illness, the statute should permit service benefits to be extended to whatever duration desired, so that employees who choose benefits on a service basis need not, in the event of prolonged hospitalization, be remitted to partial indemnity 'major medical' insurance.

"Fifth, the legislation should take account of the fact that retired employees have greater health needs and lesser financial ability to meet them than active employees, and should provide at least as great a government contribution toward health protection after retirement as before, and perhaps a greater one."

The AHA has developed legislation, in cooperation with Blue Cross and Blue Shield representatives, which can be incorporated into a health service program for government employees. Discussions have also been held with representatives of federal employee unions.

In his letter to Mr. Young, Dr.

Snoke also stated that the American Hospital Association has recommended that ". . . legislation on this subject which your commission may suggest to the forthcoming Congress be drafted to further the principles outlined in this letter. For almost 25 years this Association has fostered voluntary prepayment programs as being essential to the provision of better hospital care to all the American people, including federal employees. The principles outlined above grow out of that experience and command our full and active support."

RESEARCH GRANTS

The American Hospital Association has been given $100,000 by the Public Health Service for a research project dealing with better planning of hospital design.

MR. WOLFE

The $100,000 is available for each year of the 3-year project, which is to be carried out with the cooperation of the American Institute of Architects. Half of the first year's funds will be available March 1. Clifford Wolfe, secretary of the AHA Council on Hospital Planning and Plant Operation, will be the principal investigator.

Three other research grants were made by PHS:

- St. Vincent's Hospital, New York City, $33,600 for the first year of a 3-year project to develop scientific personnel systems and methods for hospitals. Sister Lorette Bernard, R.N., administrator of the hospital, will be project director.
- The Joint Blood Council Inc., Washington, D.C., $25,000 for the first year of a 2-year survey to develop standard terminology for describing the work of blood bank technicians and standards for use in accrediting blood banks. Dr. Frank E. Wilson, council executive vice president, will be the project director.
- University of Oregon Medical School, Portland, $4,460, for a study of needs in training medical technologists. Dr. Frank E. Queen, professor of pathology, will be the principal investigator.

DR. COGGESHALL

President Eisenhower accepted the resignation of Dr. Lowell T. Coggeshall, HEW special assistant for medical and health affairs, on Dec. 28. Dr. Coggeshall has been on leave from the University of Chicago to fill the federal post.

COUNCIL ON AGING

HEW Secretary Folsom has been elected chairman of the Federal Council on Aging. He is the first official of Cabinet rank to serve on the council.

"Designation of a Cabinet member as chairman reflects the importance attached to programs of benefit to older persons," the council stated in announcing the election.

Mr. Folsom succeeds Roswell B. Perkins, an assistant HEW secretary who recently resigned to return to private law practice.

The council consists of representatives of 13 departments and agencies which plan and coordinate federal programs in the field of aging.

HUNGARIAN DOCTORS

The Health Resources Advisory Committee has called upon the health field to integrate refugee Hungarian medical men into the profession in this country. The committee advises the Office of Defense Mobilization on health matters.

Dr. Howard Rusk, chairman of the department of physical medicine and rehabilitation at the New York University-Bellevue Medical Center, New York City, is chairman of the advisory group.

DR. RUSK

MR. FLEMMING

Arthur S. Flemming, ODM director, urged health organizations and agencies having service or training opportunities for Hungarian physicians, dentists, medical and dental students, and other health personnel now entering the United States to contact the following organizations:

- American Hungarian Federation, 527 Mills Building, N.W., Washington, D.C.
- Catholic Relief Services, National Catholic Welfare Conference, 149 Madison Avenue, New York City.
- Church World Service, 215 4th Avenue, New York City.
- Hungarian League of America Inc., 30 East 30th Street, New York City.
- International Rescue Committee Inc., 65 West 45th Street, New York City.
- Lutheran Refugee Service, 235 4th Avenue, New York City.
- Tolstoy Foundation Inc., 300 West 58th Street, New York City.
- United HIAS Service, 435 Lafayette Street, New York City.

ADVISORY COMMITTEE

Formation of an Expert Advisory Committee for the professional Nurse Traineeship Program has been completed by the Public Health Service. Since its authorization by Congress last July, this project has distributed 553 traineeships among 56 schools of nursing and public health.

The following will serve on the advisory group:

Dr. Robert Berson, University of Alabama; Lawrence J. Bradley, director, Genesee Hospital, Rochester, N.Y.; Ann Burns, chief, Division of Nursing, Ohio State Department of Health; Rt. Rev. John J. Flanagan, S.J., executive director, Catholic Hospital Association; Ada Fort, dean, School of Nursing, Emory University; Frances Frazier, head of graduate program in public health nursing at Teachers College, Columbia University.

Also, Lulu W. Hassenplug, dean, School of Nursing, University of California at Los Angeles; Katherine Hoffman, assistant dean, School of Nursing, University of Washington; Helen Nahm, director, Department of Baccalaureate and Higher Degree Programs, National League for Nursing; Agnes Ohlson, president, American Nurses' Association; Marguerite Paetznick, director, Denver General Hospital Nursing Service, and Margaret Filson Sheahan, director, Nursing Service, University of Chicago Clinics.

INSURANCE JURISDICTION

A brief challenging the Federal Trade Commission's claim to jurisdiction over interstate advertising by health and accident insurance companies has been filed in the U. S. Court of Appeals in New Orleans.

The brief, offered by the American Life Convention and the Life Insurance Association of America, was described as "the first federal

court case testing the Federal Trade Commission's claim."

To date, the FTC has brought charges of misleading advertising against more than 40 health insurance concerns. The underwriters contention has been that FTC is intruding into an area under jurisdiction of the individual states.

NATIONAL SICKNESS SURVEY

The National Survey of Illness and Disability is now being organized by Forest E. Linder, Ph.D., until recently chief of the United Nations' Demographic and Social Statistics Branch. Mr. Linder is planning for special and continuing surveys of the amount, distribution and effects of illness and disability, plus the types of medical services furnished.

MR. LINDER

Surveys soon to be undertaken will be the most comprehensive ever attempted in the health field. Techniques will include door-to-door sampling. Public Health Service Surgeon General Leroy Burney said that the data obtained each year will ". . . be of great value to all public and private agencies working to advance the nation's health."

PUBLIC ASSISTANCE CASES

One of the first administration requests to be made of the 85th Congress will be a supplemental appropriation to take up the slack resulting from the changed formula for public assistance payments. The exact amount to be asked is now being computed and cleared with various agencies.

Under Public Law 880 (84th Congress) the formula for computing federal payments for public assistance recipients was changed, effective Oct. 1, 1956.

The formula provides that for the blind, the aged, and the totally and permanently disabled, the federal share of the first $30 payment shall be four-fifths, and thereafter up to $60, the government share is on a 50-50 basis. Previously the federal government paid up to 80 per cent on the first $25. For aid to dependent children, the law increased federal payments by $2 a month.

YEAREND SUMMARY

In a 1956 yearend statement, Secretary Folsom summed up his

Busy staffs have long valued

IVORY'S EFFICIENCY

99 44/100 % PURE

IT FLOATS

You'll like Ivory's

PURITY

MILDNESS

ECONOMY, too!

In countless hospitals across the land, patients look forward to their daily bath with mild Ivory. And busy nurses welcome the precious time they can save while giving them —thanks to Ivory's fast-lathering properties and unequaled cleansing efficiency!

What's more, Ivory is 99 44/100 % pure. Its rich, abundant lather is mild enough for even the tenderest skins. And for a soap combining so many fine qualities, Ivory's cost is surprisingly modest.

It's easy to understand why Ivory has earned overwhelming acceptance in America's finest hospitals. *More doctors recommend Ivory than any other soap!*

Procter & Gamble

department's achievements. He took particular note of federal programs directed toward building better health for the nation.

Federal appropriations to the National Institutes of Health were cited as an outstanding example of the federal government's new role in making steady progress toward better health. Secretary Folsom said that more than $180 million had been allocated by the National Institutes for medical research, most of which will be carried out by individual hospitals and universities.

He said that 3,000 research grants, totaling $39.5 million had been made to independent scientists working in universities and other medical centers.

Other examples of federal legislation listed by Secretary Folsom were: grants to build research facilities; financial aid for training more nurses and more public health personnel, and a continuing annual national illness survey.

Secretary Folsom took note of the nation's continued need for hospital construction when he said, "last year more than 200 federally aided general hospitals were built or were under construction, and more than 200 nursing homes, rehabilitation centers, chronic disease hospitals, and diagnostic and treatment centers were approved for construction under the expanded hospital construction program."

Stating that the American people had reached record levels in health, education, and economic security, Mr. Folsom called for continued attack by governmental aid on the ". . . causes of human want and hindrances to human welfare." He said, "we cannot let pride in past accomplishments dim our perspective and slacken our effort—for even greater gains are there for attainment in the changing years ahead."

MEDICARE PROGRAM UNDERWAY

Defense Department officials report that the government's new program for providing uniform care to servicemen's families is well underway. It went into effect on Dec. 7.

When the program is fully operating, as many as 800,000 dependents not now getting medical care at military facilities, or through civilian resources, will be participating in the program known as "medicare."

For the first 7 months of the program (until July 1) the Defense Department has budgeted $41 million.

DENTAL OFFICERS

A competitive examination for the appointment of dental officers in the regular corps of the Public Health Service will be held March 26-29 at a number of locations throughout the country. Applications must be received by the surgeon general's office no later than Feb. 15.

Appointments of officers to ranks equivalent to the Navy rank of lieutenant junior grade and lieutenant will be made. Active duty as a commissioned officer with the Public Health Service fulfills Selective Service System obligations.

Application forms and further information may be secured from any PHS installation or from the Surgeon General, Public Health Service, Washington 25, D.C.

ADVANCEMENT OF HOSPITALS—

Hospital Practices Studied in Symposium

Problems arising out of rapidly evolving practices in the fields of medical and institutional care were analyzed in a symposium, "The Hospital and the Sequence of Care," conducted by the American Association of Hospital Consultants Dec. 27 in New York City.

The symposium, presided over by AAHC President Dr. Jack Masur, was held in connection with the 123rd meeting of the American Association for the Advancement of Science. Dr. Masur is director of the Public Health Service Clinical Center at the National Institutes of Health.

The first part of the program was devoted to a discussion of hospital facilities in relation to the degree of illness. Dr. Vane M. Hoge, assistant surgeon general,

DR. HOGE

DR. MASUR

PHS, who introduced the topic, explored ways in which institutional care can be provided at the least possible cost consistent with the requirements of the individual patient. In order to provide such care, he said, facilities and services must be tailored to meet those individual needs.

The trend away from the specialized hospital which began in the 1930s is still going on, Dr. Hoge said. The inclusion in the general hospital of even the most traditionally specialized patients, *i.e.*, those with tuberculosis or mental disease, is an increasing practice, he said.

Although the art and science of hospital design has made great progress in the past decade, Dr. Hoge said, little thought has been given to the relative needs of different degrees of illness. "Our modern hospitals are, for the most part, built around the needs of the acutely ill patient," he said.

RESULTS OF STUDY

Dr. Hoge said numerous studies of the patient load in general hospitals have shown that upward of 20 per cent of the patients could have been handled just as well in less expensive facilities.

Dr. Hoge cited the current trend toward intensive treatment units as a forward step in suiting facilities to the degree of patient need. For example, he said, the postoperative recovery room is on the way to becoming standard in general hospitals with an active surgical service.

"Since the recovery room has proved to be a device of great value in providing better patient care, it is only logical that the same concept should be extended to cover a longer period of intensive care," Dr. Hoge said.

Dr. Hoge suggested that since there are special advantages in segregating critically ill patients there may also be advantages in segregation at the opposite end of the sickness scale. Self-help nursing units described by Dr. Hoge as appropriate for this group would care for convalescents, those in the hospital for observation and diagnosis, and others with minor disabilities. He said if special units were built for such cases the cost should be much less per bed than that of the regular general hospital.

In the second part of the sym-

You can expect more from . . .

American

THE AMERICAN LAUNDRY MACHINERY COMPANY

American's Planning Service adds value to every dollar you invest in laundry equipment

A plan means a place for every piece of equipment.

A plan is a *living thing*, which takes into consideration the passage of time and your continuing growth. It is a *right now thing*, since new equipment must begin paying for itself immediately. It is a *far seeing thing*, making sure that new equipment can be smoothly integrated with future improvements.

American's Planning Service begins with your present, studies your past, and maps out your future. It consists of helpful suggestions based upon the experience of American's Man from the Factory. Carefully detailed drawings, worked out by an engineering team whose business is efficiency. Making the best use of your present equipment, thoughtful selection of new equipment whose basic design is drawn from over 89 years of experience.

A plan that works, that contributes to your success, that is most practical and economical for you, is another way you can expect more from American.

You can expect more from . . .

American

The American Laundry Machinery Company, Cincinnati 12, Ohio

posium, a discussion of the relationship of the convalescent home to hospital care, George Bugbee, president of Health Information Foundation, said one of the greatest planning problems facing the hospital field is a definition of the functions of nursing homes and other fractional hospitals.

"Such a definition must make clear each fraction's objectives and resources and must, in effect, delineate the trained personnel needed to meet those objectives," Mr. Bugbee said.

There is no generally accepted definition of the services to be expected by the public or the medical profession which largely controls the flow of patients to various types of hospitals, Mr. Bugbee continued.

Administrators of 26 voluntary convalescent homes in the New York area have found much variation in objectives and in admitting procedures, patient care levels, and demand for service, Mr. Bugbee reported.

"The most pressing problems of a majority of these convalescent homes have been the effects of changing medical treatment and the need for convalescent care as reflected in patients referred by physicians practicing in the community," he said.

MR. BUGBEE

One factor of importance, Mr. Bugbee said, is the virtual disappearance of certain illnesses which had required long-term convalescent care in the past.

Quoting from a report of the United Hospital Fund of New York on the problem, Mr. Bugbee said the basic need today is a clear understanding of the needs of convalescent patients and the medical and allied services which convalescent institutions should be expected to provide.

HOME CARE

The role of home care was considered in the final part of the symposium. Dr. Basil C. MacLean, commissioner of hospitals of New York City, described the home care services established 8 years ago in 16 New York hospitals. In the past 2 years, he said, the program has become relatively stabilized with an average daily census of 2,200 patients on all programs.

"The average cost per patient day on home care is now about $3.50, compared to our $23 per diem costs in general hospitals," Dr. MacLean reported.

In the New York program, he said, the hospital physician decides whether the patient requires home care. In addition to medical, nursing, and social services, physiotherapy and occupational therapy are given by technicians of the hospital. In the plan, a clear distinction is made between the home care recipient and the outpatient.

"Home care is no longer utilized merely to relieve a bed, although this secondary benefit is a good one, but because the patient can be cared for adequately and more economically on that service," Dr. MacLean said.

PHARMACY SECTION

A system that provides close control of narcotics and hypnotics as they are transferred from department to department within the hospital was described by Arthur W. Dodds at a session of the pharmacy section of the American Association for the Advancement of Science.

Mr. Dodds, who is director of pharmaceutical service at the Public Health Service Hospital, Staten Island, N. Y., said such a "hospitalwise" security system would leave the hospital less vulnerable to mismanagement charges in the event of disappearance of narcotics.

The session at which he spoke was co-sponsored by the AAAS Section on Pharmacy and the American Society of Hospital Pharmacists.

"Some institutions, in setting up their narcotics controls system, seem to forget that a system to be as foolproof as possible must be a hospitalwise and not a departmental system," Mr. Dodds said.

Studies of various control systems have shown that security controls and cross checks are often lacking between nursing station medication centers and the pharmacy or drug room, Mr. Dodds said. In some cases, no checks were made on items delivered to a nurse to ascertain if the narcotic was properly logged in at the nursing station record in the correct amount, if it was used, or if it is still "on hand" at the nursing station.

The system described by Mr. Dodds places responsibility for the control of narcotics and hypnotics on one person—the pharmacist, if there is one on the hospital staff. It also provides information on usage rates in various areas.

Using eight forms, the system covers the flow of controlled drugs from the point of requisition, purchase and actual arrival at the hospital through to their ultimate destination—actual administration to an inpatient or the release of drugs via prescription to outpatients.

NEED MODERN METHODS

Professor S. B. Jeffries of the Brooklyn College of Pharmacy called on hospital management to devote more energy to developing and using modern business procedures for the management of drug and pharmaceutical resources.

Greatly increased utilization of hospital beds, along with higher operating costs and expansion of technical facilities for the treatment of disease, have made such measures mandatory, Mr. Jeffries said.

He reported that a survey of 21 New York hospitals "disclosed the appalling fact that important as drug facilities and resources have become, both functionally and financially, to the efficient operation of the hospital, management controls and safeguards have remained, for the most part, almost rudimentary."

The survey also showed that:

- Excess capital was invested in pharmaceuticals.
- Losses due to inventory shrinkage amounted to as much as 10 per cent of the dollar value of pharmaceutical supplies.
- Patient medication charges did not reflect the total cost of operating the prescription department.

Mr. Jeffries outlined a study that could be made by hospitals to show whether fundamental financial and operational procedures involved in managing drug resources were sound.

CARE IN DRUG USE

Dr. Stuart M. Sessions, assistant director of the Clinical Center of the National Institutes of Health, drew attention to the hazards involved in the use of investigational drugs in medical research.

He listed two distinct types of hazard: (1) jeopardy to the life or relative state of well-being of the research subject, and (2) jeo-

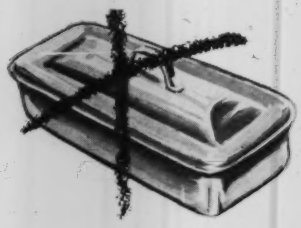
pardy to the subject's chances for cure of his illness through withholding or delaying established therapeutic procedures.

Potential dangers of a clinical study must be clearly explained to the subject, he said, and voluntary agreement based on informed understanding must be obtained from the patient.

A survey in which cost figures were compared for administering drugs by the disposable unit method and the conventional syringe and needle method was reported by Dr. James A. Hunter, medical officer in charge, Public Health Service Hospital, Detroit.

Although the disposable unit method was found to be slightly more expensive than the conventional method, Dr. Hunter said, certain advantages of closed system therapy tend to justify the increased cost.

"As demand grows for disposable unit medication and as the drug industry tools to disposable unit packaging," he said, "it can be expected that the cost differential as identified in this study will be further reduced."



For Patient Protection

Your PETROLATUM GAUZE MUST NOW BE U.S.P.

The U.S. Pharmacopeia—Revision XV[1]—lays down the following specifications for making petrolatum gauze:

1. Gauze and petrolatum must be sterilized separately:—
   a) Dry Gauze to be sterilized in an autoclave at 121° C. (250° F.) in an atmosphere of steam for 30 minutes.
   b) Petrolatum to be oven-heated to 170° C. (338° F.), then maintained at 165°-170° C. (329°-338° F.) for two hours.
2. Components must be combined aseptically.
3. The finished product must meet U.S.P. sterility tests[2].
4. Each petrolatum gauze unit must be packaged individually to maintain sterility.

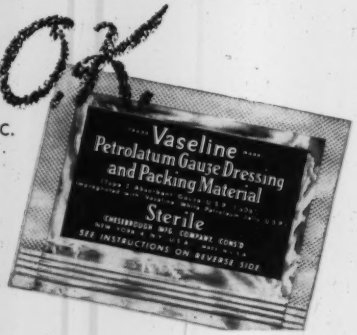
(1) U.S.P. XV, pp 304-305. (2) U.S.P. XV, pp 841-846.

VASELINE® PETROLATUM GAUZE *is* U.S.P.

AND COSTS LESS THAN MAKING YOUR OWN PETROLATUM GAUZE

For further information, write
CHESEBROUGH-POND'S INC.
New York 17, New York

VASELINE is the registered trademark of Chesebrough-Pond's Inc.



British Doctors Discuss Pay With Government Officials

British government officials and doctors in the state-controlled national health service were to meet Jan. 4 to discuss an increase in pay requested by the doctors.

The government now pays doctors at the rate of $6,160 a year. The doctors have asked for an annual salary of $7,560 to meet the rising cost of living in Britain. Involved in the wage issue are 22,000 general practitioners and 18,000 consultants and hospital staff members.

If the issue is not settled satisfactorily, the British doctors have threatened to go on "strike." The "strike" would not affect patients; doctors would continue to work but would refuse to accept their government salaries, which have remained unchanged since 1951, the British Medical Association stated.

Charles G. Roswell Rejoins New York Hospital Fund

Charles G. Roswell has rejoined the United Hospital Fund of New York as director of the Hospital Services Division. Mr. Roswell served the fund as assistant director and consultant on accounting from 1940 to 1954.

Mr. Roswell is a member of the Federal Advisory Committee on Hospital Facilities and Services. In 1945, he was appointed to the faculty of the Columbia University School of Public Health.

LeRocker Named Director Of Sloan Hospital Institute

Frederic C. LeRocker has been appointed director of the Sloan Institute of Hospital Administration and professor of hospital administration in the Graduate School of Business and Public Administration at Cornell University, Ithaca, N. Y.

MR. LeROCKER

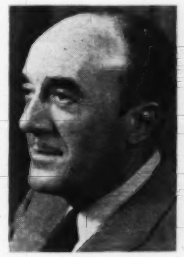
Mr. LeRocker has been director of support activities at the Memorial Center for Cancer and Allied Diseases in New York City for the past year. He will be the first director of the institute.

The institute was established in 1955 under a basic grant of $750,000 from the Alfred P. Sloan Foundation "to make possible a

new experimental program in hospital administration, designed to provide a balance between an administrative and management emphasis on the one hand and health program consideration on the other."

Military Surgeons Give Medal to Dr. Armstrong

Dr. George E. Armstrong has been named the 1956 recipient of the Founder's Medal of the Association of Military Surgeons of the United States. Dr. Armstrong is vice president of medical affairs at New York University and director of the NYU-Bellevue Medical Center.



DR. ARMSTRONG

The medal is awarded to association members who have made an outstanding contribution to military medicine and who have given conspicuous service to the association. Presentation was made in Washington.

Dr. Armstrong was surgeon general of the Army from 1951 until 1955, when he retired with the rank of major general. He was a trustee of the American Hospital Association in 1952-54.

Veterans Group Honors Rehabilitation Worker

Russell C. Williams of the Veterans Administration Hospital in Hines, Ill., has been named to receive the National Rehabilitation Award, the highest honor of the American Veterans of World War II.

MR. WILLIAMS

Mr. Williams has been chief of the rehabilitation center for sightless veterans at the hospital since 1947 and prior to that was engaged in rehabilitation work at Valley Forge General Hospital. Mr. Williams was blinded by an exploding shell in France in the Second World War.

He is the central figure in the VA training film, the "Long Cane," which has been distributed nationally to demonstrate techniques used at the Hines center to rehabilitate the blind.

The rehabilitation chief is the fifth person to receive the National Rehabilitation Award which was created 15 years ago as an annual award.

Mr. Williams, a graduate of Central Normal College, Danville, Ind., has also been the recipient of awards from the Blinded Veterans Association and the Association for Physical and Mental Rehabilitation.

Civil Defense Hospital Test Indicates Longer Patient Stay

A 10-member team of mass casualty experts has concluded after 2 field tests that, 200-bed Federal Civil Defense Administration emergency hospitals would have to care for a larger number of injured for a longer period of time than originally assumed, if used under field conditions.

The recent Battle Creek, Mich., meeting grew out of field tests made by the Army Medical Corps and centered around FCDA's 200-bed emergency hospital, now being distributed to state and city civil defense units across the nation. The test indicated that the hospitals would have to care for a larger number of injured, and for a longer period of time than the

A New
NIGHTINGALE
Economy-Styled
Lamp
Contemporary styling and 12", 12 pound base for stability, makes this low cost Nightingale floor lamp a useful and attractive addition to offices and hospital rooms.
Lamp is full 55" high . . . 12" ventilated reflector rotates 360 degrees around stationary socket.
Standard finish, Nightingale Tan baked enamel . . . custom finishing in solid or two tone color combinations available on request.
Bulb shield for inside of reflector available at slight additional cost.
Approved by Underwriters' Laboratories, Inc.
Model No. 407
Nightingale
AJUSCO
Lighting
SINCE 1911
Adjustable Fixture Co.
E. Mason and Front St., Milwaukee 2, Wis.

three weeks originally assumed.

Final recommendations for improving the mass casualty care program are to be made in the near future.

1957 Hospital Construction Estimated at $775 Million

Public and private hospital-institutional construction in 1957 is expected to reach $775 million, according to forecasts by the federal Departments of Labor and Commerce. This represents an increase of 23 per cent over the $630 million spent in hospital-institutional construction in 1956.

The upturn in construction, which has been declining slightly since the peak year of 1954, is attributed in part to "the influence of increases in federal aid funds."

It is estimated that private construction will account for $400 million of the $775 million total. The remainder is to be spent for public construction.

Filmstrip on Volunteers Available From Association

"In-Service," a filmstrip outlining the steps necessary to organize a hospital volunteer service program, has been made available by the American Hospital Association. The filmstrip, made from slides prepared by auxiliary members throughout the country, is a project of the Council on Hospital Auxiliaries. Rent for the film is $4 for three days and $1 for each additional day.

The filmstrip comes in three forms: filmstrip with record for use in automatic projector; filmstrip with record for use in manually-operated projector, and individual slides with script.

Letters should be addressed to the AHA Film Library.

Tuberculosis Hospital Opens For Other Chronic Diseases

All Saints' Hospital for the Treatment of Tuberculosis, Philadelphia, has announced plans to open its doors to patients suffering from other chronic diseases. The hospital's tuberculosis service will be continued.

The Rev. Arnold Purdie, executive director of the Philadelphia Episcopal City Mission, reported on Nov. 20 that a joint committee composed of representatives of the hospital's governing board and members of the hospital staff is now at work planning the organization, policies, and physical equipment necessary to put the new project into effect.

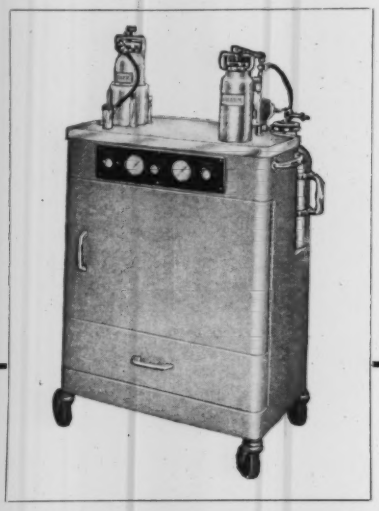
"This project," Mr. Purdie said, "is one we have had in mind for a long time in order to meet a critical community need for the treatment of chronic diseases in addition to the service that All Saints' Hospital has been rendering to tuberculosis patients for nearly 80 years. **The grant which we received from the Ford Foundation last spring has made it possible to start on this program long before any of us had ever dared hope we should be able to.**"

As presently envisioned, the hospital is planning a three-year pilot project to accomplish its purpose, following recommendations by Dr. A. P. Merrill, superintendent of St. Barnabas Hospital, New York City.

Medical Library Scholarships Given for Summer Courses

Eight $150 scholarships for courses in medical library work are to be given by the Medical Library Association, the group has announced.

The scholarships apply for work during summer sessions at the library schools of Columbia University, Emory University, the University of Illinois, and the University of Southern California.



Heavy-Duty—EXPLOSION-PROOF HERB-MUELLER Ether-Vacuum Apparatus

The AS-7 Herb-Mueller Ether-Vacuum Unit provides the ultimate in dependability for your operating room. It keeps the patient properly anesthetized with an even flow of controlled ether vapor, and maintains a powerful vacuum up to 25 inches Hg for clearing the operative field. Features include:

- Explosion-proof 1/6 hp G.E. motor and twin pumps, noiseless and vibration-free.
- Exclusive Mueller Re-Circulating Oil System minimizes pump maintenance.
- Eye-level panel for convenient use of gauges and controls.
- Quart and gallon suction bottles with quick-change tops.
- Ether bottle, refillable without removing.
- Pyrex ether warmer and ether filter.
- Reinforced steel cabinet mounted on 4" conductive casters. Stainless steel top and gray hammerloid enamel finish are ether-proof and stain-resistant. Overall cabinet height is 47", requires a space 29" wide 15" deep.
- Operates on standard 115-volt, 60 cycles AC.

AS-7 Herb-Mueller Ether-Vacuum Unit .....Each $595.00

MUELLER & CO.

330 South Honore Street
Chicago 12, Illinois
Dallas • Houston • Los Angeles • Rochester, Minn.

One scholarship will go to each of the four schools and four more will be awarded to worthy candidates in any of the four locations.

March 1, 1957, is the association's closing date for scholarship applications. Candidates must already have been accepted by the school of their choice by that date.

Further information and application forms may be secured by writing to the library schools of the individual universities.

Michigan Bone Bank Possible With Use of Nuclear Reactor

A $1 million nuclear reactor at the University of Michigan may permit the establishment of a central bone bank for Michigan, a university surgeon said at ceremonies dedicating the reactor on Nov. 16.

Dr. Paul H. DeVries said "with the reactor at our disposal it is conceivable that the University Medical Center could sterilize large amounts of these tissues, and service hospitals all over the state as a central supply."

Dr. DeVries has been working with the problem of preserving and sterilizing human bones, blood vessels, and cartilage for transplants on patients. He has been attempting to establish a bone bank at the University Hospital for two-and-a-half years.

Practical Nursing School Opens at New York Hospital

St. Luke's Hospital, New York City, has announced that its board of trustees has approved the opening of a school for practical nursing.

The Muhlenberg School of Practical Nursing will offer a 12 month course leading to a license as a practical nurse in New York State. The school expects to admit its first class on Jan. 28. Both men and women will be accepted for training.

OFFICIAL NOTES

(Continued from page 87)

ganized structure of the Blue Cross Association established a mechanism for the further extension of the voluntary system of nonprofit prepayment for hospital services and does not of necessity change the basic relationship between hospitals and Blue Cross Plans, and in recognition of the inherent intent of the reorganization and the integrity of its administrators, the American Hospital Association reaffirms its approval of the Blue Cross Association and urges hospitals to assist in implementing programs that may be developed by the Blue Cross Association."

NOTE: In presenting the recommendation of the Council on Prepayment Plans and Hospital Reimbursement with regard to the Blue Cross Association, the chairman of the council covered the following issues in an introductory statement:

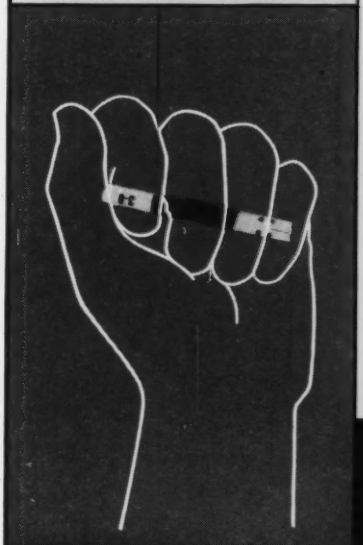
1. In addition to declaring Blue Cross Plans approved by the American Hospital Association eligible for membership in the Blue Cross Association, the revised bylaws of the Blue Cross Association grant the Board of Governors authority to declare "any other nonprofit health service prepayment plan" eligible for membership.
2. The statement of purposes in the Blue Cross Association revised bylaws gives almost unlimited authority for the development of national programs, some of which are not the responsibility of the Blue

NEW

Saves time
Simplifies O.R. procedure

Actual Size

DEKNATEL
dry sterile
READI-WOUND
LIGATURE REELS



- Size is clearly marked *on reel.*
- Length of reel insures *proper fit in hand.*
- No need for holders of any kind.
- Eliminates whiplashing, tangling.
- Reduces O.R. handling to minimum. Merely open sterile tube and ligature is ready to use.
- Dependable Deknatel Surgical Silk and Cotton. Five yards per reel, 3 dozen reels in jar or can, *dry sterile.*

Samples submitted upon request.

J. A. DEKNATEL & SON, INC.
QUEENS VILLAGE 29, NEW YORK

Cross Commission of the American Hospital Association.

3. The revised bylaws of the Blue Cross Association no longer specify direct representation from the American Hospital Association on the Board of Governors, as was the case when the Blue Cross Commission served as the Board of Governors.

***VOTED:** To approve the use of the Blue Cross name and symbol by the Blue Cross Association on behalf of licensed Blue Cross Plans which are or will become members of said association, with the right to reconsider such approval in the event of any fundamental change in the Blue Cross Association's Articles of Incorporation and/or bylaws as accepted July 10, 1956, it being understood that any proposed amendment to the Articles of Incorporation and/or bylaws shall be filed with the American Hospital Association prior to formal adoption.*

FUND-RAISING COUNSEL

***VOTED:** To accept the Requirements for Listing Fund-Raising Counsel (see below) as criteria for determining eligibility for listing by the Association; further,*

To investigate eligibility of fund-raising counsel for listing and to review the eligibility of those listed at least every two years; further,

To establish a reasonable fee to cover the administrative costs of investigating eligibility for listing; further,

To place responsibility for recommending fund-raising counsel for listing by the Association with the Committee on Accepting Hospitals for Listing; further,

To publish the list of Fund-Raising Counsel Accepted for Listing by the American Hospital Association; further,

To permit fund-raising counsel accepted for listing by the Association to state: "Accepted for listing by the American Hospital Association," provided this privilege shall obtain only so long as the fund-raising counsel continue to be listed; further,

To accept advertising in HOSPITALS, Journal of the American Hospital Association, from fund-raising counsel only if they are accepted for listing by the Association, and further,

To accept exhibits at the annual convention from fund-raising counsel only if they are accepted for listing by the Association.

REQUIREMENTS FOR LISTING FUND-RAISING COUNSEL

PREAMBLE

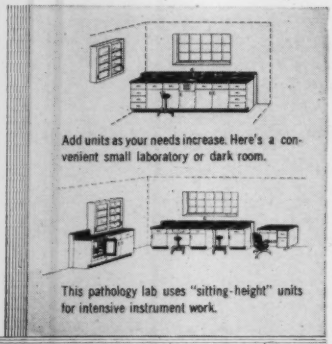
Capital fund-raising campaigns are a critical factor in determining whether a hospital can obtain funds to allow it to meet the needs of the public which rely on the hospital for care. As a service to member hospitals and to community groups planning fund-raising campaigns for new hospital facilities, the American Hospital Association compiles a list of fund-raising counsel which meet the Requirements for Listing Fund-Raising Counsel established by this Association.

The Association does not recommend any one individual or fund-raising firm. Hospitals and community groups considering employment of a fund-raising counsel are advised to make their own investigation of the firm of their choice to determine that firm's competence and suitability for the particular project. Prior to completing negotiations to employ counsel, the hospital should interview the staff member of the fund-raising counsel who will act as campaign director to determine that individual's fitness for the campaign.

It is accepted practice in the fund-raising field to include in the contract a provision for termination of the campaign by the hospital upon giving due notice to the counsel. Hospitals are urged to include such a provision

FISHER
UNITIZED
FURNITURE

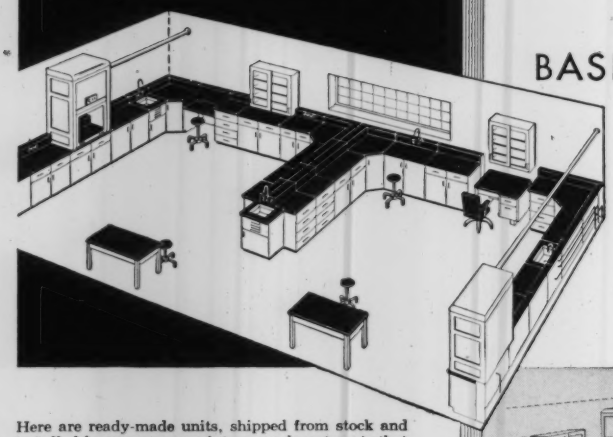
gives you a "custom" laboratory with "standard" units.



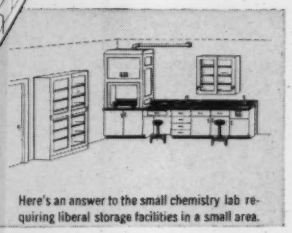
Add units as your needs increase. Here's a convenient small laboratory or dark room.

This pathology lab uses "sitting-height" units for intensive instrument work.

28
BASIC UNITS
Immediately Available from Stock



Here are ready-made units, shipped from stock and installed by your own maintenance department, that give you all the advantages of a "made-to-order" laboratory at a "mass production" price! Order only the units needed now . . . add others as your needs expand. Choice of Kemrock, Formica or Stainless Steel tops.



Here's an answer to the small chemistry lab requiring liberal storage facilities in a small area.

This Planning Guide shows you how

26 pages of useful information to help you create a truly functional laboratory.

write for your copy
131 Fisher Bldg., Pittsburgh 19, Pa.

FISHER SCIENTIFIC
America's Largest Manufacturer-Distributor of Laboratory Appliances & Reagent Chemicals

Boston, Cleveland, Pittsburgh, Buffalo, Detroit, St. Louis, Chicago, New York, Washington, Charleston, W. Va., Philadelphia, Montreal • Toronto

B-21b

in their contracts with fund-raising counsel to cover unforeseen contingencies which may arise after the start of the campaign.

The Association investigates with due care applicants for admission to the List of Fund-Raising Counsel and charges a fee for so doing. This fee is to help defray the cost of investigations. Accordingly it is not returnable to any applicant that fails to qualify. The Association makes no charge for listing per se.

REQUIREMENTS

1. *The management or the firm shall be registered under the laws of the home state, shall have been engaged in professional fund-raising activities for at least five consecutive years immediately preceding admission to the listing prepared by the American Hospital Association, and shall have successfully completed at least five fund-raising campaigns.*
2. *The fund-raising counsel staff shall not participate in any campaign which utilizes paid solicitors for solicitation of funds or engages in unethical use of the mails.*
3. *The professional fee charged and the general overhead expenses shall be based on the number of personnel assigned to the project and on the time required to complete the project. Firms basing their fees on the amount of the campaign goal, on the amount actually pledged, on a percentage basis, or using similar methods shall not be eligible for listing.*
4. *The professional fee for the fund-raising counsel shall be identified separately from general overhead campaign expenses, such as printing, entertainment, publicity, and office rental. General overhead campaign expenses shall be established in budget form and approved by the hospital in advance of the campaign.*
5. *The fund-raising counsel shall conduct a pre-campaign survey to determine the soundness of the proposed project before final acceptance of a campaign project. It shall be acceptable to charge a reasonable fee for such surveys.*
6. *The fund-raising counsel shall submit promptly to the client a final report of the completed campaign, including recommendations for future activities by the client as to collection of pledges and similar matters.*
7. *The fund-raising counsel shall demonstrate financial stability and reliability.*
8. *The fund-raising counsel shall be recommended for listing by the appropriate committee of the American Hospital Association. The American Hospital Association reserves the right to withhold listing of any fund-raising counsel which in its judgment operates in any manner which is not in the interests of the hospitals and the public.*

CURRENT LISTINGS OF NEW ASSOCIATION MEMBERS

NEW INSTITUTIONAL MEMBERS

CALIFORNIA

Mojave—Mojave Hospital.

FLORIDA

Gainesville—University of Florida J. Hillis Miller Health Center Teaching Hospital and Clinics.

MINNESOTA

Melrose—Melrose Hospital.

NEW YORK

Buffalo—St. Joseph Intercommunity Hospital Inc.

TEXAS

Jourdanton—Mercy Hospital.

NEW PERSONAL MEMBERS

Atkinson, William S.—student—University of Michigan—Ann Arbor.

MISS PHOEBE

NO. 15 IN A SERIES

"Why? Oh, just because I've already *done* everything *else* in my E & J chair, I guess!"

E & J

Your E & J chairs rate headlines, too. Not only are they economical (they simply refuse to wear out)—they also show that you provide *the finest* for patient comfort and safety. Beautiful, folding E & J chairs are more than good equipment—they're *good public relations.*

Specify **EVEREST & JENNINGS** chairs for your hospital

EVEREST & JENNINGS, INC., 1803 PONTIUS AVE., LOS ANGELES 25, CALIF.

Brewer, George M.—student in hospital adm.—Northwestern University—Chicago.
Burnies, Maj. Harrison G.—USAF MSC—student in hospital adm.—Baylor University—Brooke Army Medical Center—Fort Sam Houston, Tex.
Busby, Leroy W., Jr.—student in hospital adm.—State University of Iowa—Iowa City.
Colloton, John W.—administrative associate—University Hospitals—Iowa City, Iowa.
Dauterive, Dr. Henry J.—superintendent Dauterive Hospital Inc.—New Iberia, La.
Dowling, John P.—executive dir.—Milton (Mass.) Hospital and Convalescent Home.
Eisleben, Robert Kelly—student in hospital adm.—State University of Iowa—Iowa City.
Garbe, Raymond William—architect—Schmidt, Garden and Erikson—Chicago.
Gdalman, Louis—dir. of pharmacy—Presbyterian-St. Luke's Hospital—Chicago.
Greene, Omar V., Jr.—student in hospital adm.—University of Pittsburgh—Pittsburgh.
Hall, Philip J.—student—Graduate School of Public Health—University of Pittsburgh—Pittsburgh.
Hines, Joseph J.—student in hospital adm.—Columbia University—New York City.
Hinkes, Jules Melvin—student in hospital adm.—University of Pittsburgh—Pittsburgh.
Hogberg, Gunnar Gustaf—student in hospital adm.—State University of Iowa—Iowa City.
Holbrook Capt. Robert W.—student in hospital adm.—Baylor University—Army Medical Service School—San Antonio, Tex.
Hufton, Wilfrid Lionel, II—student in hospital adm.—University of Michigan—Ann Arbor.
Hurst, O. Ray—executive dir.—Texas Hospital Association—Dallas.
Jacobson, Robert M.—management officer, 6604th USAF Hospital—New York City.
Jaskol, Joseph Michael—student in hospital adm.—University of Pittsburgh—Pittsburgh.
Joel, William—student in hospital adm.—Columbia University—New York City.
Keberreis, John B.—student in hospital adm.—Army Medical Service School—Fort Sam Houston, Tex.
Kuhns, Kenneth K.—maintenance engr.—Valley View Hospital—Glenwood Springs, Colo.
Lambert, Francis, E.—student in hospital adm.—Northwestern University—Chicago.
Larson, Robert H.—student in hospital adm.—State University of Iowa—Iowa City.
Laughlin, Major Thomas, Jr.—USA—student in hospital adm.—Baylor University—Brooke Army Medical Center—Fort Sam Houston, Tex.
Lewis, Janet H.—student in hospital adm.—University of California—Berkeley.
Lewis, John Boyd—student in hospital adm.—Yale University—New Haven, Conn.
Linden, Charles Robert—student in hospital adm.—State University of Iowa—Iowa City.
Locke, William D.—student in hospital adm.—Northwestern University—Chicago.
Marsala, Lt. Col. Anthony J.—student in hospital adm.—Army Medical Service School—Brooke Army Medical Center—Fort Sam Houston, Tex.
Marsh, Lt. Col. Edwin S.—student in hospital adm.—Baylor University—Army Medical Service School—Fort Sam Houston, Tex.
Mazen, Dr. Ahmed Kamel—student in hospital adm.—Columbia University—New York City.
Miller, Edward J.—student in hospital adm.—State University of Iowa—Iowa City.
Moore, Lt. Col. Arlice J.—MSC—student in hospital adm.—Army Medical Service School—Brooke Army Medical Center—Fort Sam Houston, Tex.
Morin, Frank F.—student in hospital adm.—University of California—Berkeley.
Myers, Robert J.—student in hospital adm.—University of California—Berkeley.
Nordham, Robert—administrative intern—Duke Hospital—Durham, N. C.
Patana, Col. W. S.—student in hospital adm.—Army Medical Service School—Fort Sam Houston, Tex.
Patrick, Floyd Albert—student—State University of Iowa—Iowa City.
Poole, Jerry Eugene—student in hospital adm.—State University of Iowa—Iowa City.
Sister Gladys Rideout, R.N., M.T.—assistant adm.—Langlade County Memorial Hospital—Antigo, Wis.
Roessling, Adolf H.—architect—Smith, Hinghman and Grylls Inc.—Detroit.
Roper, Paul H.—student in hospital adm.—State University of Iowa—Iowa City.
Schofield, William H. III—student in hospital adm.—University of Toronto—Toronto, Ontario, Canada.
Schuckerow, Joseph F.—student in hospital adm.—Columbia University—New York City.
Simmons, David Earl—student in hospital adm.—State University of Iowa—Iowa City.
Sessoms, Dr. Stuart M.—assistant dir. Clinical Center—National Institutes of Health—Bethesda, Md.
Simon, Philip P.—administrative officer—Clinical Center—National Institutes of Health—Bethesda, Md.
Smith, David M.—administrative resident—Shannon West Texas Memorial Hospital—San Angelo, Tex.
Snelling, James H.—student—Baylor University—Army Medical School—Fort Sam Houston, Tex.
Thaden, Jerry Allan—student in hospital adm.—State University of Iowa—Iowa City.
Tucker, John O.—student in hospital adm.—Northwestern University—Chicago.
Van Bree, Kenneth—student in hospital adm.—Northwestern University—Chicago.
Verzi, Lt. Col. Martin A.—MSC—student in hospital adm.—Army Medical Service School—Fort Sam Houston, Tex.
Weinstein, Bernard M.—student in hospital adm.—University of Pittsburgh—Pittsburgh.
Wilder, Windsor D.—student in hospital adm.—Northwestern University—Chicago.
Willis, David P.—student—University of Pittsburgh—Pittsburgh.
Zint, Frederick J.—student in hospital adm.—State University of Iowa—Iowa City.

Personal news

(Continued from page 75)

Deaths

● SARKIS J. ANTHONY, M.D., died in December at the age of 45. Dr. Anthony was superintendent of the Edward J. Meyer Memorial Hospital, Buffalo, N. Y.

● FRANCIS S. DIXON, M.D., died October 3, aged 55, of coronary thrombosis. Dr. Dixon had been superintendent of the Natchez Charity Hospital, now the Natchez General Hospital. He also served on the staffs of the Natchez General Hospital and the Natchez Sanatorium and Benevolent Association where he died.

● MARK H. EICHENLAUB, former superintendent of the Western Pennsylvania Hospital, Pittsburgh, died December 27. He served as first vice president of the American Hospital Association in 1948.

Mr. Eichenlaub retired as superintendent of the Western Pennsylvania Hospital in 1953 after 30 years in that position. A leader in hospital administration in Pennsylvania, Mr. Eichenlaub was active in the Southwestern Hospital Conference of Pennsylvania, the Hospital Council of Western Pennsylvania and the American Hospital Association. He was a charter member of the American College of Hospital Administrators and was also a member of its board of regents, 1950-53.

MR. EICHENLAUB

● RALF HANKS, past president of the Missouri Association for Mental Hygiene, died September 24, aged 61, of cerebral hemorrhage. He served as superintendent of state hospitals in Nevada, St. Joseph and Fulton, Mo.

● RUSSELL S. SPAULDING, executive consultant for the New Hampshire-Vermont Blue Cross and Blue Shield Plans, died at Concord (N. H.) Hospital, December 26. He was 57 years old. Mr. Spaulding had served as executive director of both Plans from 1943 to 1956, when he gave up these duties because of ill health and was appointed executive consultant.

MR. SPAULDING

Mr. Spaulding served on the actuarial commission of the Blue Cross Commission, was a member of the New Hampshire Hospital Advisory Council, secretary of the New Hampshire Hospital Association, and a member of the American Hospital Association.

● CAROL V. WELLER, M.D., chairman of the University of Michigan Pathology Department for 25 years and teacher and nationally known pathologist, died December 10 in Ann Arbor.

Although on retirement furlough from the University since June, Dr. Weller served as editor-in-chief of the *American Journal of Pathology*, a post he had held since 1941. He was also active as chairman of the Scientific Advisory Board of the Armed Forces Institute of Pathology.

Dr. Weller contributed greatly to the records of medical reporting, having written more than 100 articles and 5 books during his 45 years as a member of the University medical faculty.

Must a mental hospital superintendent be a physician psychiatrist? No.

(Continued from page 37)

the superintendent spends more

drug-stower

REVOLVING CABINET FOR PHARMACIES

★ 180 various size drawers

★ contains 360 lineal feet of shelving

★ requires only 4½′ x 4½′ of floor space

Automation in your prescription department! Just think . . . your entire stock of drugs concentrated into a space no larger than 4½′ x 4½′!

The DRUG-STOWER consists of three vertical tiers of drawers and compartments (180 in all) ingeniously built into an attractive cabinet. A slight touch of your hand rotates the tiers and brings the section you want to the front. All drawers are numbered to facilitate indexing and locating of drugs.

The mechanism is simplicity itself. The revolving tiers rotate freely in either direction on large ball thrust bearings; equipped with foot brake for smooth stopping.

For complete information about the DRUG-STOWER . . . the space, time and step saver for pharmacists . . . write for Bulletin No. 5.

HASCO-BIL since 1912

G. A. Hasemann Mfg. Co.

2357 S. SEVENTH ST. • ST. LOUIS 4, MISSOURI

INDIVIDUAL SERVICE

SUGAR, SALT PEPPER PACKETS at LOWER PRICES than you have ever paid

VAN BRODE

Moistureproof . . . Polyethylene-lined

Now you can buy the finest quality cane sugar, weather-proofed salt and purest black pepper in moisture-proof, cakeproof individual service packets.

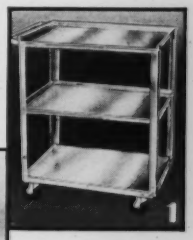
Priced considerably less than you have ever paid for individual service sugar, salt, and pepper packets.

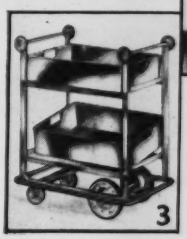
See your distributor or wire or write for information to

VAN BRODE MILLING CO., INC.
SUGAR DIVISION Clinton, Mass.
PACKERS FOR THE SUGAR TRADE

EDWARD DON & COMPANY

Carts for EVERY Bus Need!





For example, (**1**) the all stainless steel UTILITY CART for light bussing. Eliminates carrying heavy trays and dishes. Operates silently.

The rugged stainless steel TRAY TRUCK (**2**) is available in 5- and 6-shelf models. Easy-gliding casters with rubber wheels that won't mar floors.

The stainless steel DISH TRUCK (**3**) has two deep stainless steel trays for removing soiled dishes and glassware without carrying and the added risk of breakage.

Yes, here at DON you'll find carts for every purpose. Yet, they're only a few of the 50,000 items of EQUIPMENT, FURNISHINGS and SUPPLIES to aid or improve your food preparation and serving.

Satisfaction guaranteed on every item. Write Dept. 7 about your specific needs now or ask for a DON salesman to call.

EDWARD DON & COMPANY
GENERAL HEADQUARTERS—2201 S. LaSalle St.—Chicago 16, Ill.
Branches in MIAMI • MINNEAPOLIS-ST. PAUL • PHILADELPHIA-CAMDEN

Save 60% in floor space with

DELUXE

VERTI-FILE

The modern way to file

With Deluxe Steel Verti-File you not only save floor space, but your cost per filing inch will be one-third the cost of conventional drawer files.

YOU'LL LIKE ALL THESE OUTSTANDING VERTI-FILE FEATURES:

- Less file clerks required—faster filing, less walking time, no drawers to open and close
- Unlimited visibility
- Reduces employee fatigue
- Increases filing accuracy
- Safer—no tripping over pulled-out drawers, no falling over step stools
- Bottom shelf, 6" off floor, protects folios from wet mopping

Adopted and approved by the Office Management Committee on Cost Reduction and Efficiency

Call your Deluxe dealer or write for new brochure

DELUXE

DELUXE METAL FURNITURE CO., Warren, Pa.
A DIVISION OF THE ROYAL METAL MFG. CO.

than a small fraction of his time in clinical practice or other nonadministrative matters.

There are at present approximately 585 mental hospitals in this country. To date, the number of psychiatrists who have been certified by the American Board of Mental Hospital Administrators (most of whom qualify on the grandfather clause rather than on the basis of special training in techniques of administration) is but 400, and training centers in administrative psychiatry are just being formed. There are today perhaps no more than 1,000 psychiatrists in the pool from which mental hospital superintendents may be drawn. However, in the community at large there are many times this number of individuals who possess all, or a large part, of the skills necessary to qualify as good mental hospital administrators. To the extent that their qualifications fall short, it is primarily in the area defined as technical skill, which also is the area most easily learned under proper training conditions.

It seems that the entire problem can best be restated as follows. In the broadest sense, is it possible and more efficient to recruit mental hospital administrators exclusively from psychiatrists or to include, additionally, men with demonstrated administrative ability who are not psychiatrists? In answering this question it is necessary to consider the amount of time and effort necessary to qualify one as a diplomate in psychiatry. It is also necessary to consider that there is a severe shortage of psychiatrists in the area of clinical practice where the psychiatrist is obviously best qualified to handle this responsibility. Finally, it is necessary to remember that men with demonstrated administrative ability, who are not psychiatrists, can be trained in the special and more technical aspects of mental hospital administration.

In choosing a mental hospital superintendent, our preference would be, of course, a psychiatrist who is a good administrator. But not finding a person with both qualifications, we would choose a good administrator rather than a psychiatrist lacking administrative ability. ■

Insurance coverages needed during construction

(Continued from page 40)

explosion, collapse, underground work or contractor's protective. The limits of liability under the contractor's insurance should be adequate for the situation. If it does not work an undue hardship on the contractor, it is preferable to have his insurance on the occurrence basis rather than an accident basis. Accident implies a sudden, unusual happening while occurrence is broader in scope, not being limited to a particular instant.

With contractor completely protected for work, the owner should give consideration to his own liability for the work to be done. Some ways of meeting this problem are:

1. Requiring the contractor to add the name of the owner to his insurance policy.
2. Including a hold harmless clause in the contract and requiring the contractor to insure such hold harmless agreement.
3. Requiring the contractor to purchase an owner's protective policy in the owner's name.

A combination of these methods would probably result in a satisfactory solution from the coverage standpoint.

If the owner already has a "comprehensive" type of liability insurance, the necessary protection is automatic. If a "schedule" type policy is carried, the owner should request his insurance carrier to add insurance in the "independent contractor's" section of the owners', landlords' and tenants' liability policy. The reason for this recommendation is that the owner already has determined an insurance company of his choice and has fixed adequate limits. Using another party's insurance or outside agreements is awkward and dangerous.

The owner should assign a competent person to review the final contract for any clauses or workings that would lead to "assumed liability" by the owner. Such agreements must be called to the attention of the insurance carrier and covered by "contractual liability" insurance. The same person could review the evidences of

HOSPITAL PLAQUES

and signs for every purpose in
BRONZE and ALUMINUM

THE OPERATING UNIT
OF THIS HOSPITAL WAS GIVEN
IN LOVING MEMORY OF
JOSEPH BROWN WHITEHEAD, JR.
1950

SURPRISINGLY LOW COST
Everlasting beauty.
Free design service.

Hospitals from coast to coast have gotten the *best* for *less* because of our unsurpassed facilities and years of nationwide experience. It will pay you to look over our new catalog, prepared especially for our increasing clientele in the hospital field. Why not send for it today . . . now!

GIBNEY
MEMORIAL WING

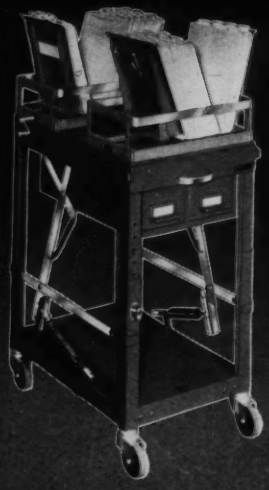
Room and Door Plaques
Directional Signs
Dedicatory Plaques
Memorial Plaques
Building Facade Letters
Plaques to Stimulate Fund Raising

"Bronze Tablet Headquarters"

Write to
UNITED STATES BRONZE SIGN CO., INC.
570 Broadway, Dept. H, N. Y. 12, N. Y. • *Plant at Woodside, L. I.*

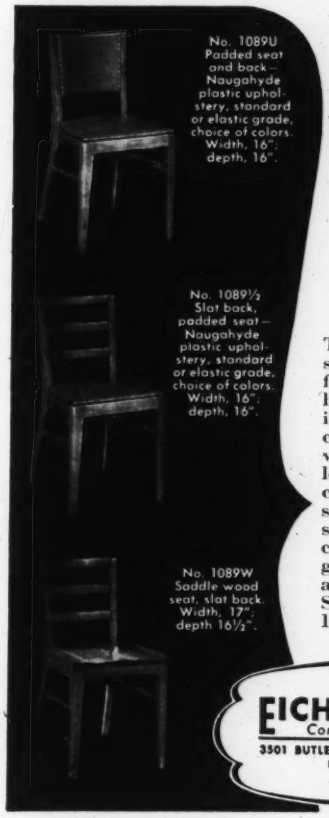
THE *BEST* POSTING TRAYS and STANDS HAVE ALWAYS COME FROM - -

Le Febure ...and always will!



Ask for Demonstration . . . Representatives in Most Principal Cities

Le Febure
CORPORATION • CEDAR RAPIDS, IOWA


No. 1089U
Padded seat and back—Naugahyde plastic upholstery, standard or elastic grade, choice of colors. Width, 16"; depth, 16".
No. 1089½
Slat back, padded seat—Naugahyde plastic upholstery, standard or elastic grade, choice of colors. Width, 16"; depth, 16".
No. 1089W
Saddle wood seat, slat back. Width, 17"; depth 16½".

Save Your Walls with "WALL-SAVER" CHAIRS

These chairs pay for themselves by protecting walls from damage. Their flared back legs prevent "rocking" or tipping — chair can't scratch walls and woodwork. Sturdy and long-lived — solid birch construction. One piece steam bent apron and stretcher, reinforced corners. Metal cushion glides. All finishes available. Back height, 14½". Seat height, 18½". Weight, 18 lbs.

Write for Bulletin 1005-A

EICHENLAUBS
Contract Furniture
3501 BUTLER ST., PITTSBURGH 1, PA.
ESTABLISHED 1873

Improved
TETRA®
Bandage

Rubber Reinforced Elastic
All Cotton Rubberless

NOW! . . . the last word in an all new, improved live rubber, heat resistant elastic bandage. (Each polyethylene wrapped . . . with metal clips.) A worthy companion to our All-Cotton Rubberless Elastic Bandage . . . **proved the best for over 40 years.**

If you like the bandage you're using . . . you'll like **TETRA** better!

Economical . . . Superior Quality

SPECIAL HOSPITAL PRICES

THE **TETRA** COMPANY
350 North Clark Street, Chicago 10, Illinois

Without charge please send sample of _____ inch bandage. (Indicate type: Cotton _____ or Rubber _____)

Name_____

Hospital_____

Address_____

insurance offered by the contractor. ■

Hospital association meetings

(Continued from page 6)

Nurse Anesthetists Institute — January 28-February 1; Detroit (Statler Hotel)
Hospital Auxiliary Leadership Institute—January 31-February 1; Dallas (Baker Hotel)
Central Service Administration Institute—February 11-14; Atlanta (Henry Grady Hotel)
Nursing Service Supervision Institute—February 25-28; Chicago (Shoreland Hotel)
Hospital Planning Institute — February 25-March 1; Chicago (Edgewater Beach Hotel)
Evening & Night Nursing Service Institute—March 11-14; Roanoke (Roanoke Hotel)
Medical Record Library Personnel Institute—March 11-15; Chicago (Shoreland Hotel)
Hospital Dentistry Institute—March 13-15; Washington (Willard Hotel)
Hospital Organization Planning Workshop—March 18-22; New York (New Yorker Hotel)
Staffing (Nursing) Institute—March 25-27; Chicago (Shoreland Hotel)
Hospital Engineering Institute — March 25-29; Denver (Olin Hotel)
Nursing Inservice Programs Institute—April 4-5; Chicago (Congress Hotel)
Management Development Workshop—April 8-12; Boyes Springs, Calif. (Sonoma Mission Inn)
Improvement of Patient Care Institute—April 22-23; Kansas City, Mo. (Hotel President)
Obstetrical Nursing Service Administration Institute—April 22-25; Boston (Somerset Hotel)
Occupational Therapy Institute — April 22-26; Seattle (Olympic Hotel)
Hospital Auxiliary Leadership Institute—April 25-26; Atlanta (Atlanta Biltmore Hotel)
Hospital Dietary Department Administration Institute—May 20-24; Dearborn, Mich. (Dearborn Inn)
Administrators' Secretaries Institute — May 14-17; New York City (Waldorf Astoria Hotel)
Directors of Hospital Volunteers Institute—May 15-17; Chicago (Blackstone Hotel)
Nursing Inservice Programs Institute—May 27-28; Boston (Somerset Hotel)
Hospital Organization and Hospital Planning Institute — June 6-7; Chicago (Shoreland Hotel)
Hospital Law Institute — June 10-11; Chicago (Edgewater Beach Hotel)
Medical Social Workers Institute—June 10-14; Washington, D.C. (Willard Hotel)
Hospital Personnel Administration Institute—June 10-14; St. Louis (Coronado Hotel)
Nursing Service Administration Institute—June 17-21; Ottawa, Canada (Chateau Laurier)
Hospital Pharmacy Institute—June 24-28; Seattle (Olympic Hotel)
Developing the Skills of Supervising Institute—June 24-28; Chicago (Edgewater Beach Hotel)
Hospital Public Relations Institute—June 25-28; Boston (Sheraton Plaza Hotel)

Who controls your hospital?

(Continued from page 43)

and questioned.

Periodically, both administrator and comptroller should examine, in detail, the bills paid by the hospital. It is surprising what such examination can reveal. For instance, if it is noticed that credit memorandums are very infrequent among the purveyors' invoices, it may be that the receiving clerk is not properly checking incoming merchandise. (Errors in shipments received, both as to quantity and quality, are not unheard of.) A further review of the bills might very well point out great variations in the weights of meat, indicating that specifications are not being adhered to.

An administrator should also periodically request that each department present to him its work schedule. While it may seem that very little information can be obtained from such procedure, further inspection may lead to such questions as, why three housemen are required on one day, two on another. There may be a good reason, but at least the administrator should know of it. The administrator can also profitably examine admittance records and floor census counts. Some hospitals have seasonal variations which are quite marked. If room assignments are properly watched, it is often possible to eliminate certain areas from service with the accompanying payroll saving.

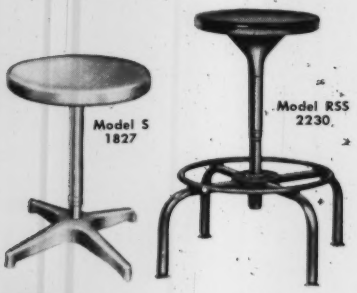
Department heads presumably watch these things. However, they will watch them much more closely if they realize the administrator will notice the extent of their performance. People are always more interested in doing a better job if they realize their superior is interested in what they are doing.

Control of the hospital, then, is a matter of team work. No member of that team can pass on his responsibility to another. Neither can any member of that team properly exercise his function without the complete cooperation of the other members. ■

AJUSTRITE®
LABORATORY
CHAIRS & STOOLS

Since 1935—AJUSTRITE (formerly Kewaunee Everhold) have been used in many outstanding laboratories. Improvements in both design and construction have made AJUSTRITE the most complete selection of sizes and types for laboratory use.

32 MODELS IN THE AJUSTRITE LINE



Stool No. S1827 adjusts 18" to 27", and RSS 2230—22" to 30". Other sizes with 15" low to 36" high. Five seats—Round steel, wood, formed plywood, solid hardwood saddle and upholstered seats and backrests available.

GUARANTEED
against failure due to defective material or workmanship for a period of 10 years.

FREE TRIAL

Send for illustrated catalog, choose any model and try for 30 days without obligation to yourself the many advantages of AJUSTRITE Chairs and Stools in Laboratories.

SPLIT SECOND ADJUSTMENT ... to any Height Desired

AJUSTO EQUIPMENT COMPANY • 515 Conneaut St., Bowling Green, Ohio

prn

PRO RE NATA

JOHN H. HAYES

No matter how small the sum of your worldly goods you can still afford the luxury of helping others.

★ ★ ★

The Communists are now boasting that there are one million TV sets in Russia. We have over 41 million.

Maybe the people over there don't care for the sponsor's "commercials."

★ ★ ★

SNAKE HOLLOW HOSPITAL CHRISTMAS NOTES: One of our male patients, on hearing the Nurses' Glee Club singing "Hark the Herald Angels Sing," thought he had died and gone to Heaven. He did not feel reassured until his wife visited him and told him that he would not hear that kind of music where he was going.

Dick Kingle lost his job as Santa for our children's ward, due to his dieting during the year. Clint Hudkins, who won the pie eating contest at our picnic last summer, took his place.

We congratulate our interns and nurses upon their art work in decorating the hospital for Christmas with lip rouge, shoe whitening and tempera; but we can't understand what sailing ships, flying birds, dogs, etc., have to do with the season.

Bachelor Pete Torgensen has a bright idea. He suggests that married men who receive outlandish neckties from their wives for Christmas give the ties to our hospital. He says we can then sell them back to the wives next Fall and, in that way, provide a continuing source of income for our hospital.

★ ★ ★

Advertising—in print or on the air—amuses me. For instance, today nearly everything to eat, to wear, to use as a cosmetic, etc., is now called "fabulous."

Webster says that "fabulous" means "based on a fable; fictitious—like a fable in exaggeration; passing belief, etc."

The word "fabulous" comes from the word "fable," which means something *not* to be believed. And usually I don't.

★ ★ ★

What this country needs is an acceptable definition of what we call "bedside nurses."

And a dictionary of the present teen-age language, so that parents could better understand their children.

★ ★ ★

When I was young I was scolded for wearing my Sunday clothes on weekdays. Now I get heck because I want to wear my old clothes on Sunday.

"It doesn't look nice," she says.

★ ★ ★

Now that leap year is over, the girls will still propose to the men, but continue to make the men think that they did it.

IDLE HOURS BANISHED

With Portable Bedside TV by ROLEE

Ideal AUXILIARY or Gift Shop Project

CUSTOM-DESIGNED FOR HOSPITALS . . . GET THE MOST WANTED FEATURES to assure the very finest in hospital television quality and performance. They're all in PORTABLE BEDSIDE TELEVISION BY ROLEE.

The set is a 14" RCA, custom-designed for hospitals, 115 volt, 60 cycle, AC operation, power transformer, aluminized picture tube, safety glass, UL Commercial power cord. The exclusive ROLEE ALL-CHANNEL REMOTE CONTROL turns the set on or off, selects channels, regulates volume, and permits use of Hi-Fidelity remote speaker, TV speaker, or both.

15 DAYS TRIAL OFFER

NO OBLIGATION IF RETURNED IN 15 DAYS

HOSPITAL DESIGNED

- Television Stands
- Remote Controls
- Hi-Fidelity Remote Speakers
- Master Antenna Systems
- Closed Circuit TV and Radio Systems

ROLEE *HOSPITAL TELEVISION, INC.*

2720 Oak Lawn Avenue • Dallas, Texas

( ) Send one Rolee TV Unit on your 15-day trial offer:
With ( ) All-Channel or ( ) Single-Channel Remote Control.

Please send full information as follows:
( ) Direct Purchase Plan ( ) Rental Plan
( ) Complete Illustrated Brochure on Hospital TV

Hospital_____

Address_____

City_____ State_____

Your Name_____ Title_____

ATTACH TO YOUR LETTERHEAD OR PURCHASE ORDER

CLASSIFIED ADVERTISING

JANUARY 16

Classifications: Classified advertising accepted to run under the following headings: 1—Services; 2—Instruction; 3—Wanted; 4—For Sale; 5—Positions Wanted; 6—Positions Open; 7—Miscellaneous.

Transient Rate: Twenty-five cents a word; minimum charge $3.50 per insertion.

Contract Rate: Six-point body lines, 13 pica columns, $1.15 per line; eight-point display lines $1.40 per line. Five per cent discount for six-insertion contracts with no change of copy.

FOR SALE

Foley Hydraulic Genital-Urinary operating table; used. Contact Purchasing Department, Michael Reese Hospital, 2900 Ellis, Chicago, Illinois.

POSITIONS OPEN

ANESTHETIST—Member of AANA; 109 bed hospital; non-profit, general. Not responsible for obstetrical anesthetics. Position open about February first. Write, Director, Retreat for the Sick, 2621 Grove Avenue, Richmond, Virginia.

DIETITIANS: THERAPEUTIC and ASSISTANT CAFETERIA MANAGER for research hospital. A.D.A. Housing aid available for finding apartment. Liberal benefits. 5 days. Please send resume and salary requirements to: Personnel Department, Memorial Center, 444 East 68th Street, New York 22, New York.

INSTRUCTOR IN CLINICAL NURSING FOR DIPLOMA SCHOOL OF NURSING: of approximately 90 students. Good personnel policies—40 hour week. Experience in teaching and degree in nursing education preferred. Starting salary $400. Address HOSPITALS, Box H-1.

DIRECTOR OF DIETETICS in a 450 bed voluntary teaching general hospital. Experience required preferably in large institution with large diabetic service and employees cafeteria. Medical staff made up of specialists in the city; school of nursing with over 200 students; active House Staff program. Staff of 8 dietitians. Salary open. Apply Administrator, Good Samaritan Hospital, Portland 10, Oregon.

PEDIATRIC CLINICAL INSTRUCTOR: for diploma school of nursing. Pediatric unit approximately 20 beds. 1½ hours from New York City. 40 hour week. Good personnel policies. Experience in teaching in pediatrics and degree in nursing education preferred. Starting salary $400. Address HOSPITALS, Box H-3.

RECORD LIBRARIAN: To supervise Medical Record Departments of two general hospitals; 186 beds and 106 beds; 15 miles apart connected by new super highway; resort area year around; college town; minimum salary $400.00 per month. Write Administrator at St. Luke's Hospital, Marquette, Michigan or Francis A. Bell Memorial Hospital, Ishpeming, Michigan.

NURSE ANESTHETIST: New 200-bed hospital, modern equipment, active department. Apply Administrator, Bradford Hospital, Bradford, Pa.

CLINICAL INSTRUCTOR IN OBSTETRICS: for diploma school of nursing. Newly modernized obstetrical unit. 75 miles from New York City. Good personnel policies—40 hour week. Experience in teaching obstetrics and degree in nursing education preferred. Starting salary $400. Address HOSPITALS Box G-99.

LIBRARIAN: REGISTERED MEDICAL RECORDS LIBRARIAN to head department. Also, opening for assistant to chief of department, in accredited hospital of 296 beds and 36 bassinetts. 40 hour week and salary open. Apply to Administrator, The Williamsport Hospital, Williamsport, Pennsylvania

SUPERINTENDENT OF NURSES: 150 bed General Hospital fully approved by Joint Commission on Accreditation. Metropolitan area, Northeast Ohio. Suitable experience required. No training school. Salary open. Address HOSPITALS, Box G-59

ASSISTANT DIRECTOR OF NURSING SERVICE: 650 bed general hospital located in industrial city (300,000 population.) Primary responsibility to plan and supervise in service program. Experience and preparation in Nursing Service Administration desirable. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

CLINICAL INSTRUCTOR in medical and surgical nursing. Approved school of 50 students. All approved policies. B.A. required. M.A. desired. Write Director of Nursing, Danbury Hospital, Danbury, Conn.

CLINICAL INSTRUCTOR PEDIATRIC NURSING: degree and experience in nursing of children required. School of Nursing fully accredited. 650-bed non-profit hospital located in industrial city (population 300,000.) 40-hour week; paid vacations; liberal benefits. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

INSTRUCTOR FOR NURSES' AIDES: General Hospital treating men, women and children. 128 adult and pediatric beds plus 24 bassinets. 40-hour week. Salary open. Apply Director, Woman's Hospital, 1940 East 101 St. Cleveland 6, Ohio.

ASSOCIATE DIRECTOR OF NURSING: 650 bed general hospital located in industrial city (300,000 population.) All new facilities-hospital opened in 1954. Experience required. Masters degree in Nursing Service Administration preferred. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

REGISTERED LABORATORY TECHNICIAN—Male or female. Small general hospital near Cleveland, Ohio. Salary open. Address HOSPITALS, Box H-10.

ADMINISTRATOR or BUSINESS MANAGER: experience necessary, salary open, 50-bed general hospital, Milwaukee area. Address HOSPITALS, Box G-97.

HOSPITAL PERSONNEL

Nurse Anesthetists
Registered Nurses
Medical Technologist

Excellent benefits including forty-hour week, four weeks vacation annually, assured annual salary increase, shift differential, non-contributory retirement plan and medical coverage. Salaries vary due to degree of qualification. NURSE ANESTHETISTS $5880.00 to 7080.00; REGISTERED NURSES $4440.00 to $6420.00; MEDICAL TECHNOLOGIST $4020.00 to $5880.00. Here is your chance to answer a challenge and to grow with it. For full details just send your name and address to Miners Memorial Hospital Association, Box #61, 110 Logan Street, Williamson, W. Va.

When progress in your field of medicine, hospital administration, nursing or laboratory work dictates a change of location, only the most advantageous opening deserves your interest. Likewise, when your hospital or clinic requires well qualified personnel on the administrative level, diplomates to head departments or ancillary personnel, only the best available candidate is acceptable. At this juncture, you can gain time and efficiency by delegating the details of your search to the Woodward Medical Personnel Bureau. Our service is strictly confidential. *We invite your inquiries—and your attention to our excellent listings in the forthcoming first-of-the-month issue.*

MARY A. JOHNSON ASSOCIATES

AGENCY

11 West 42 Street — New York 36, N.Y.

Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidates, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists and other supervisory personnel.

No registration fee

THE MEDICAL BUREAU

M. Burneice Larson—Director

900 North Michigan Ave.

Chicago 11, Illinois

To physicians, hospital administrators, nursing executives and others in the hospital and medical fields confronted with the delicate but important problem of relocating, the physician in need of an associate, or the institution reorganizing or augmenting its staff. Burneice Larson offers the services of The Medical Bureau. All negotiations strictly confidential. Opportunities in all parts of America, including countries outside continental United States. Please note our descriptions of opportunities in the first issue of each month of Hospitals. Write us please for further details.

ALFRED E. RILEY

MEDICAL EMPLOYMENT SERVICE

59 East Madison Street, Chicago, Illinois
Andover 3-5663

Alfred E. Riley, R.N., MSHA, Director
Dorothea Bowlby, Counselor

• • •

An organization offering personal and individualized employment counseling and placement service.

Conscientious and discriminating attention is given to all individuals and hospitals served by our organization. You can negotiate confidentially with confidence.

• • •

Positions are available on all levels from beginners to executives for:

Physicians, Administrators, Executive Hospital Personnel, Medical Record Librarians, Laboratory and X-Ray Technicians, Anesthetists, Dietitians, Nurses: Directors, Instructors, Supervisors, Head, and Staff. Write us today regarding these interesting positions. Our negotiations are ethical and confidential.

HOSPITAL PERSONNEL BUREAU

220 E. Lexington St.,

Baltimore 2, Maryland

Administrators, Physicians, Nurses, Technicians, Dietitians, Librarians, and other categories. Mail resume, photo. No registration fee. Mr. Cotter, Licensed Employment Agent. LE 9-5029, Res. RI 7-3356.

CLASSIFIED ADVERTISING

REGISTERED DIETITIAN: Qualified to assume full department head duties if necessary. 156 bed general hospital located in Central Ohio. Complete details upon request to Administrator, Marion General Hospital, Marion, Ohio.

SCIENCE INSTRUCTOR FOR DIPLOMA SCHOOL OF NURSING: approximately 90 students. 75 miles from New York City. 40 hour week. Good personnel policies. Experience in teaching in science and degree in nursing education preferred. Starting salary $400. Address HOSPITALS, Box H-4.

REGISTERED NURSE ANESTHETIST 50 bed new modern hospital. Pleasant working conditions, good personnel policies. Adequate provision for week-ends and days off. Two weeks paid vacation at end of year. Salary open. Write HOSPITALS, Box H-6. State age, training and experience.

RECORD LIBRARIAN — Registered. For new 300-bed hospital. Full charge in setting up new installation. Located 30 minutes from New York City. Write stating education and experience. Address HOSPITALS, Box H-13.

LIBRARIAN, MEDICAL RECORD—Registered. To assume charge of record room. 135 bed general hospital, 40 hours—salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland, Ohio.

STAFF DIETITIAN: Therapeutic (A.D.A. member) to supervise tray service and related employees and patient contact for hospital completing expansion to 500 beds. Entirely new department. Dietetic program integrated with approved school of nursing. Affiliated with medical research institute. Sick leave, social security, hospitalization insurance, 40 hour week, 2 weeks vacation, 6 holidays, etc. Contact Miss Rosemary Brown, Dietitian Director, Toledo Hospital, Toledo 6, Ohio, or telephone collect to Lawndale 1121.

OPERATING ROOM CLINICAL INSTRUCTOR: newly modernized operating room. 268 bed hospital. 1½ hours from New York City. Diploma school. 40 hours a week. Good personnel policies. Experience in operating room. Teaching and degree in nursing education preferred. Starting salary $400. Address HOSPITALS, Box H-2.

NURSE ANESTHETIST: 42 bed, 8 bassinets, fully accredited general hospital. Salary and commission. Attractive personnel policies. LaCrosse Hospital, 13th & Badger, LaCrosse, Wis.

DIRECTOR OF NURSES: Experienced, no degree necessary. No school. 140-bed approved hospital. Social security and hospital retirement plan. Private apartment available. Attractive salary. Population over 65,000. Also wanted, NIGHT SUPERVISOR; 15-bed PEDIATRIC HEAD NURSE. Apply Administrator, Fort Hamilton Hospital, Hamilton, Ohio.

DIETITIAN: Modern kitchen, 74 employees, liberal food budget, 600 bed fully accredited hospital. No nursing school. Social security and state retirement. Salary range $3,588-4,428. Liberal annual and sick leave privileges. Member A.D.A. preferred. Address HOSPITALS, Box H-8.

POSITIONS WANTED

CALIFORNIA HOSPITALS ATTENTION: Experienced journalist desires position as PUBLIC RELATIONS DIRECTOR. Mrs. Fran Kelly, 1831 Bridge Blvd. S.W., Albuquerque, N.M.

ADMINISTRATOR: 8 years, 250 bed general hospital. Chief accountant, administrators assistant, 4 years assistant. Experience includes planning, equipping, staffing new hospital, NACHA, 34. Address HOSPITALS, Box H-14.

Male 44; Completing Hospital Administration course. Business, Accounting, Blood Bank experience. Knowledge X-Ray. Address HOSPITALS, Box H-15.

Young man, with 7 years of diversified hospital experience as BUSINESS MANAGER. Accountant is desirous of relocating in a similar capacity or preferably as an Assistant Administrator, in the eastern half of the country. Address HOSPITALS, Box G-98.

Classified Advertising Department

HOSPITALS, Journal of the American Hospital Association

18 E. Division St., Chicago 10, Illinois

Please schedule the following advertisement for the _____ _____ issue(s) of HOSPITALS under the following heading:

_____ For Sale _____ Services

_____ Positions Open _____ Positions Wanted

_____ Instruction _____ Wanted

☐ **Check or Money Order Enclosed**

☐ **Bill the Hospital**

Signed _____

Title _____

Hospital _____

Address _____

City & State _____

Here's information on this low-cost service

Twenty-five cents a word; minimum charge $3.50 per insertion.
Deadline: 30 days preceding publication date.
Clip and mail to HOSPITALS, 18 E. Division St., Chicago 10, Illinois.

ADVERTISER'S INDEX - - - - - - January 16, 1957

Abbott Laboratories . . . . . 4, 5, Facing Page 66
Adjustable Fixture Company 93
Air-Shields, Inc. . . . . Second Cover
Ajusto Equipment Company 102
Allen-A Company 24
Allis-Chalmers Manufacturing Company
Buda Division 74
American Cyanamid Company,
Surgical Products Division 1
American Laundry Machinery Company . Facing Page 90
American Sterilizer Company 57
Ayerst Laboratories 25

Bauer & Black
Division of The Kendall Company 8, 9
Baxter Laboratories, Inc. . . . . Third Cover
Becton, Dickinson & Company 61

Carnation Company 77
Celotex Corporation 69
Chesebrough-Pond's, Inc. 92
Ciba Pharmaceutical Products 59
Classified Advertising 104, 105
Coca Cola Company, Inc. 80
Crane Company 72, 73
Cutter Laboratories 55

Davis & Geck, Inc. 1
Deknatel & Son, Inc., J. A. 95
Deluxe Metal Furniture Co.,
A Division of The Royal Mfg. Co. 100
Don & Company, Edward 99

Eastman Kodak Company 63
Eichenlaubs 101
Ethicon, Inc., Fenwal . . . . . Facing Page 18
Everest & Jennings, Inc. 97

Fisher Scientific Company 96

General Electric Co., X-Ray Dept. 14
Goodrich Industrial Products Co., B. F. 15

Hasemann Mfg. Company, G. A. 99
Hausted Mfg. Company 21
Hill-Rom Company, Inc. . . . . Facing Page 74
Hobart Manufacturing Company, Inc. 16
Hoffmann-LaRoche, Inc. 32
Huntington Laboratories 12
Hyland Laboratories 30

International Nickel Company, Inc., The 27

Jarvis & Jarvis, Inc. 22
Johnson Service Company 13

LeFebure Corporation 101
Lilly & Company, Eli 2

MacGregor Instrument Company 20
Massillon Rubber Company, The 18
McBee Company, The 7
Meinecke & Company, Inc. 6
Mueller & Company, V. 94

National Cylinder Gas Company . . . . . Facing Page 70

Otis Elevator Company 10, 11

Parke, Davis & Company . . . . . Fourth Cover
Polar Ware Company 26
Procter & Gamble Company 89
Puritan Compressed Gas Corp. 19

Remington Rand, Inc.
Division of Sperry Rand Corporation 65
Rolee Hospital Television, Inc. 103

Sexton & Company, John 83
Simmons Company 23

Tetra Company, The 101
Toledo Scale Company 79
Torrington Company 31
Travenol Laboratories, Inc. . . . . Third Cover

United Fruit Company . . . . . Facing Page 26
United States Bronze Sign Company, Inc. 101

Van Brode Milling Company 99

West Disinfecting Company 29

PICTURE CREDITS

p. 39 Photographic Department, Rhode Island Hospital

p. 48 BOTTOM: Jules Schick photography

pp. 54, 56 Washington University, School of Medicine, Dept. of Illustration

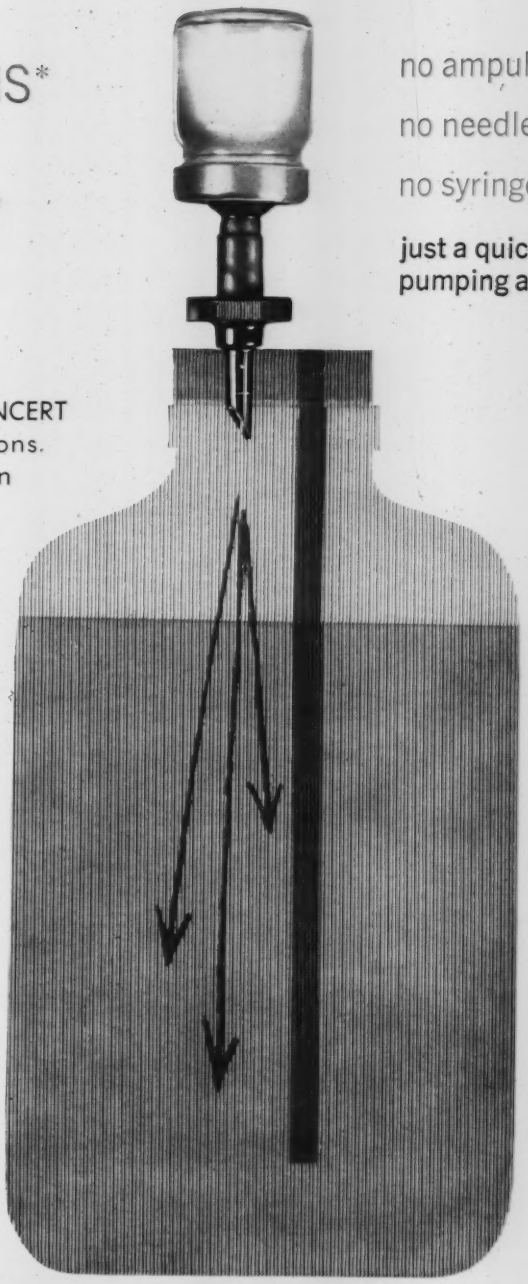
p. 60 Mason Weymouth

p. 76 Kaiser Graphic Arts

introducing

VI-CERT™ the vitamin *INCERT*®

LYOPHILIZED B VITAMINS* WITH C IN UNIQUE *INCERT* ADDITIVE VIAL



no ampules
no needles
no syringes
just a quick pumping action

Every day more hospitals are adopting the INCERT System† to supplement parenteral solutions. VI-CERT (B Vitamins with C) is now available in the unique INCERT additive vial—the only one-step sterile additive vial designed specifically for hospital use.

The INCERT vial is merely plugged into stopper of solution bottle. After vitamins are reconstituted with a few cc. of solution from the bottle, resulting mixture is pumped into the bulk solution...sterile technique is unbroken.

also available in *INCERT* SYSTEM

SUCCINYLCHOLINE CHLORIDE 500 and 1000 mg. in sterile solution

POTASSIUM CHLORIDE 20 and 40 mEq. in sterile solution

POTASSIUM PHOSPHATE 30 mEq. K^+ and $HPO_4^=$ in sterile solution

CALCIUM LEVULINATE 6.5 mEq. Ca^{++} in 10% sterile solution

*Contains Thiamine HCL 25 mg., Riboflavin 10 mg., Niacinamide 100 mg., Sodium Pantothenate 20 mg., Pyridoxine HCL 20 mg., Ascorbic Acid 500 mg.—in lyophilized form.

†developed by

TRAVENOL LABORATORIES, INC.

07856

PHARMACEUTICAL PRODUCTS DIVISION OF BAXTER LABORATORIES, INC • MORTON GROVE, ILLINOIS

when
you
prescribe

CARBRITAL®

Pentobarbital sodium and Carbromal. In Kapseal® and Elixir form.

you
prescribe
sleep

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN